Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Describe any significant changes to the approved waiver that are being made in this renewal application:

1. Unbundled the following services: Community Living and Day Supports, Integrated Community Employment, Team Behavioral Consultation, Medical Risk Services, Behavioral Risk Services, and Day Habilitation;
2. Modifications to current service definitions of Day Habilitation, Respite, Integrated Community Employment, Assistive Technology, Behavioral Risk Services, Community Living and Day Supports, Home Modification, Medical Risk Services, Personal Emergency Response Services (PERS), Retirement Services, Team Behavioral Consultation Services, Vehicle Modification, Vocational Planning Habilitation Service and Workstation Habilitation Services;
3. Additional of reserved capacity for 1)Emergency Purposes, 2) Transition Youth from Special Education services, and 3) Transition of individuals from other waivers;
4. Addition of the following new service options: Habilitative Workshop, Supported Employment – Follow Along, Environmental Modification Assessment, Transportation, Adult Day Services, Transitional Services, Habilitative Community Inclusion, Adult Companion Service, Consultative Assessment Services, and Crisis Intervention Support Service;
5. After Year 2 of the waiver period, Habilitative Workshop as a service option will no longer be available, to comport with the HCB Final Settings Rule;
6. The following service options will sunset on September 30, 2017: Integrated Community Employment, Behavioral Risk Services, Community Living and Day Supports, Medical Risk Services, Retirement Services, Team Behavioral Consultation, Vocational Planning Habilitation Service, and Workstation Habilitation Services;
7. Ability to utilize PRN psychotropic medications as prescribed by clinician within their scope of practice without review by Human Rights Committee;
8. Limitations to the following service options: Prevocational Services, Respite, Supported Employment – Follow Along, Adult Companion service, Assistive Technology, Consultative Assessment Service, Crisis Intervention Support, Environmental Modification Assessment, Home Modification, Transitional Services, Transportation, and Vehicle Modification;
9. Revisions of provider qualifications;
10. Elimination of a dispute resolution process;
11. Updated rates to support unbundled services, and
12. Change in minimum frequency for the provision of waiver services from 30 days to 60 days.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Nebraska** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
DD Day Services Waiver for Adults

C. Type of Request: renewal

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NE.0394
Waiver Number:NE.0394.R03.00
Draft ID: NE.016.03.00

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*
03/01/17
Approved Effective Date: 03/01/17

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**
Select applicable level of care
○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**
Select applicable level of care
○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:
◉ **Not applicable**
○ **Applicable**
Check the applicable authority or authorities:
☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose:

The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) offers a menu of services and supports intended to allow individuals with intellectual or developmental disabilities (DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. Employment, integration and inclusion services have been incentivized to encourage and promote the full vision of the HCBS State Transition Plan requirements that take full effect by March 2019. We are encouraging and expanding the number of types of services that are self-directed as well as offered by either an independent or agency provider to ensure the maximum flexibility for the participants served under this waiver. We are focused on informed consent of the participant, and their legal representative (if one exists), to allow choice and flexibility to purchase the services and supports which only that person may need or prefer.

Independent providers deliver participant-directed services, which are services directed by the participant, their legal representative, if one exists, or family/advocate. Services are habilitative and non-habilitative. Participant-directed services are intended to give the participant more control over the type of services received, as well as control of choice of the direct providers of those services. Provider-managed services are habilitative and non-habilitative. They are delivered by a certified DD agency. Provider-managed services may not be self-directed and independent providers do not work for certified DD agencies.

Goals and Objectives:

To offer participants an array of services available which focus on choice, employment, community inclusion and integration to meet the needs and wants of the participant by:

• Encouraging the use of community based services rather than institutionalized care in an Intermediate Care Facility for Individuals with Developmental Disabilities (ICF-DD) or nursing facility for participants whose needs can be met by community-based developmental disability providers.
• Promoting a high quality of service delivery in community-based services that supports inclusion, integration, employment and choice.
• Expanding participant direction of services.
• Providing an opportunity for participants to transition from school-based programs to adult services, thus ensuring the continuation of skill development.

Organizational Structure and Service Delivery:

DHHS DDD, a Division within the Single State Medicaid agency, administers the Day Services Home and Community Based Services (HCBS) waiver for adults with developmental disabilities. This waiver was established to transition the most vulnerable eligible young adults into the adult developmental disabilities system to prevent loss of skills and abilities; to provide needed services and community supports; and to support employment and community integration before skills become dormant.

Designated DHHS staff and a vendor enroll all agency and independent providers as Medicaid providers. DHHS staff within the Division of Public Health (DPH) certifies DD provider agencies. DDD supports the free choice of participants and their legal representatives to select from the available pool of agency-based and independent providers to deliver services and supports, with assistance provided by DDD service coordination staff, as needed. DDD service coordination is funded as a Medicaid State Plan targeted case management service. Designated DDD staff, Disability Services Specialists complete the initial level of care (LOC) evaluations, and Service Coordinators or Community Coordination Specialists complete LOC reevaluations. Services are prior authorized by DDD staff, and individualized funding is based on an objective assessment process.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The public input process for this waiver renewal was done in accordance with 42 CFR 441.304(f). The following strategies were used to secure public input for a waiver renewal:

Our extensive public input began in November-December 2015 with a series of "Let's Talk!" meetings throughout the state, presented by DDD Director Courtney Miller. In these sessions, Director Miller solicited input from participants receiving DDD services, their families, guardians, advocates and provider staff regarding the service system. She also met with DDD service coordinators throughout the state in order to hear directly from them about what was working well and what needed improvement in facilitating and providing high quality services to participants. These stakeholder meetings were influential in determining the direction of systems improvements generally and the direction of the waiver amendment specifically.

Official stakeholder engagement began with biweekly meetings in February 2016. Stakeholders were solicited by email, standing committee and trade association recruitment and personal outreach by Director Miller and her staff. Each waiver appendix had its own Stakeholder workgroup that provided input throughout that appendix's development process. Draft waiver appendices and meeting notices and minutes were posted on a dedicated webpage at:
http://dhhs.ne.gov/medicaid/MedicaidWaiverInitiative/Pages/Home.aspx. A total of forty-eight workgroup meetings were held and fifty-one updated draft appendices were posted for review and input on the dedicated website as revisions were made based on workgroup and public comment.

Because the rate-update to align with unbundling the service array had significant implications for providers, multiple additional DDD/provider meetings were held to address that subject and build a consensus on the rates in the short-term until a full rebase can be accomplished post this waiver amendment.

Additionally, monthly full group Stakeholder meetings were held where Director Miller updated the entire group as to the status of waiver development and ongoing guidance provided by CMS. Announcements and additional information can be found at http://dhhs.ne.gov/medicaid/MedicaidWaiverInitiative/Pages/MonthlyStakeholder.aspx.

Specific to Tribal Notice, the public comment period allows at least 30 days for comment before the anticipated submission date and includes written 60 day notification to all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs, and Urban Indian Organizations. Tribal Notice was distributed on August 5, 2016, November 8, 2016, and on December 23, 2016, and is available through the Division of Medicaid and DDD. DDD staff met with Tribal representative following the Medical Assistance Advisory Committee on 12/12/2016. Tribes have been provided continuous updates throughout the waiver development process including the opportunity to review the waiver amendment in its entirety.

DDD Director Miller conducted a second "Let's Talk!" statewide tour in September 2016 as one component of the public comment period. During the public comment period, DDD also solicited input through: direct conversations with tribal representatives; individuals that are eligible for DD services; waiver participants; families; guardians; advocates; the Department's public website, electronic notification to DD provider agencies and Stakeholder Listserve; the Nebraska DD provider association and advocacy groups; and non-electronic public notice in the Omaha World Herald, a newspaper with statewide circulation.

The Division's website contains public notice, the draft waiver amendment application by Appendix as well as the full waiver application, the PowerPoint slides presented at the January 3, 2017 and January 24, 2017 public meetings, and a link to e-mail questions or comments at: http://dhhs.ne.gov/developmental_disabilities/Pages/PublicComment.aspx.

To reach all stakeholders, public notice is both electronic and non-electronic. The public notice seeking public comment from December 23, 2016 through January 24, 2017 indicated that the waiver application, in its entirety or by appendix, are posted on the public website and are also available upon request in hard copy via mail, email, or by phone. The public can go to or call a local DHHS office or the DHHS central office to request a hard copy. Public comments can be provided via the internet, e-mail, fax, U.S. mail, or phone calls. Phone numbers, FAX numbers, e-mail addresses and staff names are provided on the DDD website and in the written notice.

Presentations for the public meetings consisted of a slide deck that summarized changes which were made to the appendices and discussion regarding the reason those changes were made. Questions and comments from stakeholders from each meeting were compiled at the end of the public comment period. Questions and comments are posted on the website along with resolution, which indicates that a change was made to the waiver amendment application or the reason(s) why a requested revision was not made.

When applicable, the questions and comments are resolved with additional detail or clarification from the waiver amendment application provided to the party making the comment. Comments and questions about non-waiver topics that are received during the public input period are responded to, as well.

SEE MAIN B – OPTIONAL FOR SUMMARY OF COMMENTS.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Miller

First Name: Courtney

Title: Director, Divison of Developmental Disabilities

Agency: Nebraska Department of Health and Human Services

Address: P.O. Box 98947

Address 2: 301 Centennial Mall South

City: Lincoln

State: Nebraska

Zip: 68509-8947

Phone: (402) 471-6038 **Ext:** ☐ **TTY**

Fax: (402) 471-8792

E-mail: courtney.miller@nebraska.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Nebraska**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Calder Lynch

State Medicaid Director or Designee

Submission Date: Apr 26, 2017

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Lynch

First Name: Calder

Title: Director, Division of Medicaid and Long-Term Care

Agency: Nebraska Department of Health and Human Services

Address: PO Box 95026

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509-5026

Phone: (402) 471-2135 **Ext:** ☐ **TTY**

Fax: (402) 471-9092

E-mail: calder.lynch@nebraska.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☑ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☑ **Reducing the unduplicated count of participants (Factor C).**
- ☑ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

This is an application to renew the 0394 waiver. This waiver renewal is aimed at unbundling services; limiting some of the services that are furnished under the approved waiver; placing limitations on the amount of some waiver services; changing some provider qualifications; aligning service rates with the unbundled services; and eliminating the current informal dispute resolution process while tightening the responsiveness of the complaint and fair hearings processes. All participants served in the approved waiver are also eligible to participate in the renewed waiver. This waiver renewal adds reserved capacity for emergency purposes, for Nebraska graduates who have completed Nebraska public and/or nonpublic high school transition services and have reached the age of 21, and for participants that are transferring from another waiver. In designing the service specifications for this 1915(c) waiver renewal application, the State reviewed the service arrays offered under this waiver and the utilization of services to ensure all current HCB service needs of transitioned waiver participants can continue to be met under the renewed 1915(c) waiver.

Service Changes
Respite, Home Modifications, Personal Emergency Response System, and Vehicle Modifications will continue to be offered under this waiver and retain the same title as named in the approved waiver.

The following services have been revised and renamed and will continue to be offered under this waiver:
• • Assistive Technology and Supports has been renamed Assistive Technology;
• Integrated Community Employment (ICE) has been renamed to Supported Employment – Individual. ICE will sunset September 30, 2017;
• Vocational Planning Service has been renamed to Prevocational Services. Vocational Planning Service will sunset September 30, 2017; and
• Workstation Service has been renamed to Supported Employment – Enclave. Workstation Service will sunset September 30, 2017.
•
Habilitative Workshop, Supported Employment – Follow Along, Environmental Modification Assessment, Transportation, Adult Day Services, Transitional Services, Habilitative Community Inclusion, Adult Companion Service, Consultative Assessment Services, and Crisis Intervention Support Service will be added to this waiver. While Habilitative Workshop is being added as a new service to this waiver, as such it will only be offered for the first two years of the waiver to allow transition to compliance with the HCB Final Settings Rule. During years one and two of the waiver, participants who have chosen Habilitative Workshop will be referred to the Department of Education Vocational Rehabilitation (VR) services for assessment of employment skills and abilities and development of a VR Individual Plan of Employment (IPE). Based on the individual choice, the IPE, and the DD Individual Support Plan (ISP), participants will receive employment services through VR and/or other DD day/vocational services instead of Habilitative Workshop services.

Day Habilitation, ICE, Vocational Planning Service, Workstation Service, Community Living and Day Supports, Retirement Service, Team Behavioral Consultation Service, Medical Risk Service, and Behavioral Risk Service will sunset September 30, 2017, upon transition of all participants to the new services. The services have been unbundled and revised to comport with CMS Instructions, Technical Guide and Review Criteria released January 2015, and revised based on technical assistance and feedback to drafts submitted to CMS.

Some service limitations have changed from what was previously approved. Currently, the total cost of ATS, home modifications, and vehicle modifications combined per participant per waiver year cannot exceed $5,000. In this proposed draft waiver, Assistive Technology has a participant annual budget cap of $2,500; Home Modification has a participant budget cap of $10,000 per five year period; and Vehicle Modification services has a participant budget cap of $10,000 per five year period. ATS, home modifications, and vehicle modifications that are currently authorized and therefore “in process” will continue under the current cap limitations and there will be no impact to the participant.

Impact
The health and welfare of participants whose services are ultimately going to be unbundled is of paramount importance. To ensure their health and welfare, DDD will continue its practice of a prior authorization process based on justification and the identified need of participants to obtain additional units of services not to exceed the amounts specified in Appendix C-3: waiver service specifications.

Minimizing the Impact
A transition plan is in place to address all of the major moving pieces in order to minimize the impact of the changes on current waiver participants and assure the health and welfare of affected individuals. The transition plan lays out the number of people that will have an annual, semi-annual or special meeting each month from March 2017 through September 2017. The plan or matrix breaks down the numbers by Service District, SC Supervisor, and Service Coordinator (SC) or Community Coordination Specialist (CCS) in order to evaluate workforce resources and ensure that all approximately 800 waiver participants will be transitioned to the new waiver services by September 30, 2017.

While the services are being unbundled and the names are changing, the intent is that participants will still receive services without a gap in their services. Planning steps have been taken to assure that there will be no gap in services or negative impact to the health and welfare of waiver participants that currently receive waiver services. The planning steps were as follows:
• January 2016 - Development of Nebraska DD Waiver Development Timeline – updated and reviewed weekly.
• February 2016 - Creation of dedicated website and mailbox.
• March 2016 - Creation of Management Planning Team, which is combined DDD administrative staff from Policy and Communication and Field Operations, as well as data, financial and support staff.
• September 2016- Statewide tour by DDD Director Courtney Miller to explain the waiver renewal and respond to questions, provided to participants, family members and other stakeholders.
• September 2016- Identification by DDD Central Office field management staff of number of service planning meetings needed to occur in the months of March-September for full transition to the renewed waiver by July 1, 2017.
• September-October 2016- DDD leadership hosted technical assistance videoconferences for DDD service coordinators that explain service definitions and transition to new services, using a crosswalk from current services that will ultimately be unbundled to new services.
• January 2017- Upon receipt of the final rates, the case management software (Therap) will have completed updating the rate table in order to change service authorizations.
• March 2017- Commence service planning meetings to transition participants to renewed waiver.
• March - September 2017 - Ongoing weekly tracking and evaluation of transition activities for each participant, including service coordination workload monitoring, timely meeting dates, and timely authorization of new services.
• October 1, 2017- Full transition to new services listed in waiver renewal.

Outreach to transition participants to new services
In order to successfully transition current waiver participants to the new service and provider options that will be offered under the renewed waiver, all stakeholders - waiver participants, families/legal representatives, advocacy organizations, and independent and agency-based providers - have been provided information about the continuing, new, and ending services through a variety of methods noted below. The service definition which included scope, limits to the amount, frequency, or duration, as well as provider qualifications and service rates have been shared verbally and made available in hardcopy and electronically by e-mail and on a dedicated website, at http://dhhs.ne.gov/medicaid/MedicaidWaiverInitiative/Pages/Home.aspx. Some service definitions were posted in March 2016, and the complete offering of services definitions was originally posted in May 2016 and updated in August, September and October 2016 as a result of ongoing feedback from stakeholders and CMS. Waiver participants and interested parties contacted DD central office or service coordination staff and requested hardcopies or provided e-mail addresses so that information could be sent directly via e-mail. Participants or their representative will be able to contact their Service Coordinator or Community Coordinator Specialist, or DDD central office electronically by e-mail or via a dedicated website noted above, regarding the need for assistance in locating a new provider if a current independent provider will be unable to meet the new provider qualifications and they have not been contacted directly. The state has worked continuously, meeting weekly with state staff that oversee the provider enrollment broker, to revise the electronic enrollment system and increase DHHS resources to ensure that enrollment is timely and the provider pool has adequate numbers. Weekly meetings will be ongoing to monitor progress on provider enrollment during the transition to ensure that there is no gap in provider enrollment and payment.

The materials have been distributed by DDD staff through informational meetings around the state, direct e-mails, and public website postings. Informational meetings with stakeholder workgroups, participant and public town hall forums, and DD provider associations began in February 2016 and were held in-person, via WebEx, and telephonically. E-mail addresses were solicited and a Stakeholder Listserv was created. Materials presented in hardcopy or as PowerPoint slides at the meetings were e-mailed to the Stakeholder Listserv and posted on the dedicated website following the meetings. Stakeholder workgroup meetings have occurred bi-weekly, two series of public town hall forums have been held, and DDD representatives have participated in monthly DD provider association meetings.

New materials have been developed for service coordination staff, participants and their families/guardians, independent providers, and DD agencies. Webinars are being provided to Service Coordination staff along with materials to explain the new services and timelines for completing the transition for each individual. Following the transition plan schedule outlined above and described in detail below, transitioning will begin in March 2017 and end by September 30, 2017.

FOR ADDITIONAL INFORMATION SEE MAIN-B OPTIONAL.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required. Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State's Statewide Transition Plan, last submitted May 31, 2016, is posted in its entirety on the DHHS public website at http://dhhs.ne.gov/Pages/Transition.aspx and this submission is consistent with the portions of the statewide transition plan that are germane to this waiver.

Following are the identified service setting types to be evaluated for compliance with the new rule. Setting means locations where habilitation services and/or supports are delivered. An individual's own or family home is not provider-owned, controlled or operated and therefore is not included.

DD Waiver Settings
Day Habilitation - Prevocational Workshop. Prevocational Workshop Habilitation services are formalized training and staff supports for the acquisition, retention or improvement in self-help, behavioral and adaptive skills that take place during typical working hours, in a non-residential provider-operated facility, separate from the participant's private residence or other residential living arrangement. Prevocational Workshop Habilitation services are provided to persons not currently seeking to join the general work force or participate in vocational planning services. Please note: In this waiver submission, this service is titled Habilitative Workshop.

DDD completed a comprehensive systemic assessment including: state statutes, regulations applicable to all waivers, licensure and certification tools and procedures, other current practice (e.g., monitoring by service coordinators), approved waiver applications and Medicaid provider agreements and applicable addendums to assess compliance with the final rule. A work plan for waiver-specific applications, Nebraska Administrative Code (NAC) and practices compliance is provided in Attachment 1, and assessment results for the DD waiver 0394 are provided in Attachment 4 of the Statewide Transition Plan. The referenced attachments can be found in the publicly posted plan as submitted to CMS on May 31, 2016 at http://dhhs.ne.gov/Documents/Statewide%20Transition%20Plan%20Updated%205_31_2016.pdf. Current practice is in compliance with the final rule. Specific areas targeted for improvement are education for services coordinators regarding documentation of setting options presented to individuals and landlord tenant laws. Currently, verification includes on-site monitoring by services coordinators and certification and licensure by the Division of Public Health (DPH) licensure unit. All monitoring tools will be updated to address requirements of the final rule.

Nebraska Administrative Code (NAC), Title 480, Home and Community-Based Waiver Services and Optional Targeted Case Management Services, and Title 404, Community-Based Services for Individuals with Developmental Disabilities, will be updated with additional regulations to align them with federal requirements. All NAC rules supporting the DD Waivers will be re-drafted and incorporated as chapters in Title 480. In addition, Titles 404 and 480 will be amended to include more specific language for some of the requirements, e.g., privacy and freedom in the living unit, control over schedule including food and freedom to have visitors. Detail including whether the NAC is compliant, not yet meeting HCBS characteristics, or silent is available in Attachments 2, 3 and 4 of the transition plan submitted to CMS, last submitted to CMS on May 31, 2016. The referenced attachments can be found in the publicly posted plan as submitted to CMS on May 31, 2016 at http://dhhs.ne.gov/Documents/Statewide%20Transition%20Plan%20Updated%205_31_2016.pdf.

Following, is a brief narrative describing the process for completion of the settings assessment. Site assessments were conducted as preparation for completion of the State Transition Plan and were conducted by DDD services coordinators, using a sampling methodology to verify the statistical validity of the initial round of findings and assess a sample of non-residential services providers. A randomized, stratified approach was utilized. This approach required a sample of 50 DD Waiver providers for the population. The data pull included certified and licensed sites as well as sites which served individuals receiving services based on behavioral and medical risk.

Site assessment for waiver settings evaluated specific topics organized by CMS-identified qualities and conditions for HCBS settings:
1. Integration with the greater community.
2. Selection of setting.
3. Freedom from coercion and restraint.
4. Optimization of individual initiative, autonomy, and independence.
5. Choice regarding services and supports.
6. Privacy and freedom in living unit.
7. Control over schedule, including food.
8. Freedom to have visitors.
9. Physical accessibility.

Non-residential setting assessments completed by DDD staff were categorized as follows: five (5) are categorized as fully compliant; twelve (12) are categorized as not compliant but could be with modifications; and no non-residential settings are categorized as unable to comply. Additional on-site assessments of non-residential settings will provide DDD with a larger sample size and assess compliance specific to that setting type.

Letters notifying providers of the preliminary results of their setting assessments were sent in early April 2016. Providers responded with comments regarding their results. Following completion of validation activities, DDD will clarify areas of improvement with providers, for which providers must submit provider-level transition plans. DDD will make available provider-level transition plan templates by October of 2016 and will review and provide feedback on plans from March through April of 2017. During this time, providers will continue to make progress toward compliance. Throughout 2017 and forward to March of 2019, DDD will monitor ongoing progress.

DDD plans to provide specific guidance to settings requiring heightened scrutiny regarding the State's approach in the late fall of 2016. Examples of evidence/documentation that DDD may request from providers requiring heightened scrutiny include, and is not limited to: written narratives regarding the setting and its characteristics and practices, how the setting overcomes the presumption of isolation and/or institutional in nature, evidence that individuals receiving Medicaid HCBS experience inclusion in the broader community to the same extent as those not receiving HCBS, documentation showing individualized planning and evidence that a review of a person's interests, priorities and necessary supports occurs regularly, and evidence that efforts are made to support and promote new experiences for individuals within the broader community.

Additional assessment activities for all settings requiring heightened scrutiny will be completed by the spring of 2017, including on-site visits of settings and submission of evidence packages by providers. DDD will review information gathered as a result of additional assessment activities and identify settings to be submitted to CMS in the summer of 2017 and will conduct public input for these settings throughout the end of 2017.

Remediation activities specific to the Systemic Assessment and timelines are included in Attachment 1 of the State Transition Plan. Nebraska's monitoring efforts will occur at the individual, provider and state levels. Improvement and monitoring efforts specific to the DD waiver programs, and the work plan, NAC and practices compliance (Statewide Transition Plan Attachment 1) and the work plan for settings compliance (Statewide Transition Plan Attachment 5) provide benchmarks for identified modifications, last submitted to CMS on May 31, 2016. The referenced attachment can be found in the publicly posted plan at http://dhhs.ne.gov/Documents/Statewide%20Transition%20Plan%20Updated%205_31_2016.pdf. Remediation includes implementation of a new HCBS administration rule in Title 480 that establishes the standards in the HCBS final rule for all Nebraska HCBS waiver settings. This remediation is applied for any provisions where the regulation is silent, or where there is not language to fully demonstrate all of the federal provision.

The Nebraska statute found at §76-1401 (the Uniform Residential Landlord Tenant Act) is compliant. Statute §81-2268 (Medicaid Waiver funds and use authorized) will be amended to indicate that nothing in the statute authorizes Medicaid funds to be used for disqualified settings under Nebraska or Federal law. Statute §83-1202 (Legislative intent, persons with developmental disabilities) will be amended to remove limiting language or will be applied to State-funded services only. Otherwise, State statutes are silent regarding settings requirements in the final rule.

DHHS is engaging in a concurrent initiative, Long-Term Supports and Services (LTSS) Redesign, which will impact Nebraska's Medicaid waiver programs. Changes will be needed to operating agency regulations, waivers, and policies and practices. The concept paper for the LTSS redesign effort is available at: http://dhhs.ne.gov/medicaid/Documents/LTSSRedesignConceptPaper.pdf. The Division of Medicaid and Long-Term Care (MLTC) is procuring a consultant to assess the full range of Medicaid-funded LTSS and make recommendations for service delivery, from initial access through monitoring and evaluation of outcomes. The consultant's recommendations may result in improved processes for assessment of functional needs, use of additional federal authorities for HCBS delivery and regulatory changes. In addition, the consultant will be required to engage stakeholders regarding the redesign and provide a summary report of stakeholder engagement. The LTSS redesign consultant reports and draft redesign plan are anticipated by November 2016.

The state assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements when the State's Statewide Transition Plan is approved. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Attachment #1 Transition Plan (continued)

Process to Transition
In September 2016, DDD Central Office field staff identified how many ISP meetings would need to occur in the months of March-September 2017 for full transition to the renewed waiver. Participants having semi-annual or annual ISP meetings prior to March 1, 2017 already have those meetings scheduled given that they are routinely scheduled six months in advance. DDD Central Office field management will be conducting weekly tracking of the conversion via monitoring the case management software (Therap) to ensure that the schedule is met and will intervene as necessary.

Transition for participants in the existing waiver will be phased in over a hundred twenty-day time period (i.e., participants will transition when their service plan is reviewed or their level of care is re-evaluated). At the meetings referenced above, the service coordinator will review and discuss the participant's budget and all available waiver services that will remain in this waiver. The service coordinator will assist the participant and/or family/legal representative as necessary to review their budget, determine if there will be any limitations on the amount of waiver services, and address how the limitations will be implemented. The service coordinator will assist the participant and/or family/legal representative as necessary to determine services to be purchased and to choose providers to deliver their waiver services. Some participants may choose to have the same services, same amount of services, and same providers, and in those cases, there will be very little apparent changes. When the same services are not available, the service coordinator will provide a crosswalk of the old to new waiver services and assist the participant in choosing services that meet their needs and fit into their annual budget. The participant's prospective annual budget amount is authorized prior to the ending of their current budget to ensure no gap in services.

Approximately 1055 (n.b., this is the number of participants projected for the first year of the waiver renewal, as defined in Appendix J.) annual service plans/semi-annual service plans will have been held by September 30, 2017. There are 196 DDD service coordinators with at least one participant receiving services on this waiver; therefore, the expectation is that service coordinators will complete all necessary service planning meetings specific to waiver conversion by September 30, 2017.

Phase-In Protection
During the period of time it takes to transition a person to the new services in the new service plan DDD will authorize the current waiver services on a rolling basis until the new service plan and services are approved. New service plans and service authorizations that are developed during 2017 will be approved and ready for implementation on March 1, 2017, the planned effective date of the approved waiver. The remaining service plans will be approved and implemented as the plan is developed so that by October 1, 2017, all participants will have begun their new services.

If a participant receives a 30-day termination notice from a provider or the approved waiver affects the availability of providers in certain areas, DDD is assessing vacancies providers have around the state to ensure a participant has other choices in providers and services. DDD is working with the state's contracted vendor system for provider enrollment and the contracted vendor system for case management, authorization, and claims to alleviate any possible gaps in provider enrollment, provider payment and unavailability of services.

DDD will closely monitor the transition processes outlined in the approved waiver to ensure that one hundred percent of the waiver participants have completed the transition to the new services by September 30, 2017. Designated DDD staff will generate and review weekly reports to ensure all waiver participants have participated and completed the transition process. Divisional Administrative staff will meet on a regular basis with CMS until the transition is completed.

Right to Fair Hearing
The above steps are in place to ensure that this change does not result in a loss of services or waiver eligibility. The individual prospective budget amount will remain the same and a reduction in services would only be a result of choice by the waiver participant. The participant and their guardian, if applicable are informed of the Fair Hearing process in writing during the service plan meeting.

Appendix I-2-a. Rate Determination Methods. (Continued)

Additional detail on use of wage data from BSDC and OMNI Behavioral Health for the rate determination model (reference Appendix I-2-A)

In the 2010-2011 rate rebase, DDD used a combination of provider wage survey data and Nebraska-specific Bureau of Labor Statistics (BLS) data as the basis for wage assumptions. The wages in the provider cost survey data were no longer representative of current wage rates. Therefore, DDD used wage data from two specific provider sources: the State-run Beatrice State Development Center (BSDC) and OMNI Behavioral Health. Stakeholders were involved in the discussion of where to source wage data and agreed that the BSDC and OMNI wage data were representative of competitive wages across the state for the individuals that providers wanted to hire. On January 1st, 2016, the State of NE implemented an increase to the minimum wage from $8.00/hour to $9.00/hour. Providers indicated that this has put upward pressure on wages close to minimum wage, such as Direct Care Workers. Because the most recent survey data from BLS for direct care workers was published in May 2015 and would not have accounted for this increase to the minimum wage, wages at BSDC for Developmental Technicians were used in lieu of BLS data. DDD agrees that actual provider survey data or BLS data would be more representative of wages than BSDC wages and intends to use this for setting wage rates when rates are fully rebased. Two exceptions to using BSDC and OMNI were for overnight asleep workers which assumed minimum wage and respite workers which assumed an updated 2010 survey wage that the Division updated by a proportional increase to minimum wage. The Division inflated BSDC wages from calendar year (CY) 2016, First Quarter, to the midpoint of state fiscal year 2017 (December 31, 2016). OMNI rates were not inflated since they are from the current contract and a rate change is not anticipated by December 31, 2016. The rates were inflated for cost of living considerations from when the wage rate was measured (February 2016) to when we anticipate the waiver would be approved and new rates in effect (January 2017). The adjustment was 2.3% and was based on inflation as measured by the Consumer Price Index (CPI).

Tiered Service Reimbursement: The tiered rates were a result of provider feedback to reduce billing complexity. Certain cost assumptions (e.g. staffing ratios) vary by tier within a given service. The following services have a tiered rate: Habilitative Community Inclusion and Habilitative Workshop. The reimbursement for these services are tiered based on participant's assessed level of service need, and the delivery of the service is not tiered. As noted previously, there are four tier levels based on participant's acuity. These tiers are based on the eleven acuity levels derived from a multiple regression analysis of a general linear model created by DDD in 2008. The model shows a positive correlation between the cost of supervision and the acuity of the participant. This difference in the cost of supervision based on acuity is reflected in the assumed staffing ratios for tiered services. Replacement of this model is planned as part of the Objective Assessment Process redesign work that DDD is completing in 2018.

Individual Budget Allocation (IBA) methodology. The funding for participants is determined using the Objective Assessment Process (OAP) involving information from the ICAP. This comprehensive assessment requires an objective assessment of each participant's functional abilities, maladaptive behaviors, living placement, behavioral and health factors. Funding is assigned based on this information to provide for equitable distribution of funding based on each participant's assessed needs. Data from this assessment are entered into a formula to determine the funding amount for the day services. The use of this formula ensures consistent funding based on the abilities of the participant, independent of the provider. Thus, it is an individualized budget that allows the participant to choose their provider and to receive the same level of support in terms of units of services. Funding amounts are determined for participants new to services, on a two-year cycle, prior to certain transitions, or when they have a significant change in supports or abilities that put the person at risk. Funding for Respite, Consultative Assessment Service, Crisis Intervention Support, Transitional Services, Assistive Technology, Home Modification, Personal Emergency Response System, Vehicle Modification, and Environmental Modification Assessment is not determined using an objective assessment process (OAP).

Alternative compliance to the funding tier, may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Service coordination staff complete risk screens related to Health, Physical Nutritional Management or Enteral Feeding (as applicable), Spine and Gait, and Behavioral needs. Based on input from the provider and guardian, if applicable, the team may submit a rationale for consideration to alternative compliance to the participant's ICAP score and identified tier level. A clinical review will be completed based on the alternative compliance request.

Additional Rate Calculations (continued from I-2-A)

1. Prevocational:
Independent Provider, Individual (1:1)
DCC=(A/C)(1+E)(1+F)=($16.05/1)(1+30.28%)(1+9.59%)=$22.91
Where: A=f
ICC= (DCC)(J+K) = ($22.91)(0.0402+0.1076)=$3.39
Rate = (DCC + ICC)N = ($21.91+$3.39)(0.96) = $25.25
For Small Group Rate, C=2

Agency Provider, Individual (1:1)
DCC=(A/C+H/I)(1+E)(1+F)(1+G)=($13.77/1+$17.42/9)(1+30.28%)(1+9.59%)(1+9.23%) =$24.50
Where: A=(0.75)(a)+(0.05)(d)+(0.20)(g)=(0.75)($13.10)+(0.05)($14.75)+(0.20)($16.05)=$13.77
ICC=DCC(J+K) = $24.50(0.1960+0.1076)=$7.44
Rate= (DCC + ICC)M = ($24.50+$7.44)(1.26)=$40.24
For Small Group Rate, C=2.5; Large Group Rate, C=4.5

2. Supported Employment Enclave:
Independent Provider:
DCC=(A/C)(1+E)(1+F)=($16.05/5)(1+30.28%)(1+9.59%)=$4.58
Where: A=f
ICC= (DCC)(J+K) = ($4.58)(0.0402+0.1076)=$0.68
Rate = (DCC + ICC)N = ($4.58+$0.68)(0.96) = $5.05

Agency Provider:
DCC=(A/C+H/I)(1+E)(1+F)(1+G)=($13.77/4.5+$17.42/9)(1+30.28%)(1+9.59%)(1+9.23%) =$7.79
Where: A=(0.75)(a)+(0.05)(d)+(0.20)(g)=(0.75)($13.10)+(0.05)($14.75)+(0.20)($16.05)=$13.77

ICC=DCC(J+K) = $7.79(0.1960+0.1076)=$2.37
Rate = (DCC + ICC)M = ($7.79+$2.37)(1.25) = $12.70

3. Supported Employment-Follow Along:
Independent Provider:
DCC=(A/C)(1+E)(1+F)=($16.05/1)(1+30.28%)(1+8.84%)=$5.69
Where: A=f
ICC= (DCC)(J+K) = ($5.69)(0.0402+0.1076)=$0.84
Rate = (DCC + ICC)N = ($5.69+$0.84)(0.96) = $6.27

Agency Provider:
DCC=(A/C+H/I)(1+E)(1+F)(1+G)=($16.05/1+$17.42/9)(1+30.28%)(1+8.84%)(1+9.23%) =$6.96
Where: A=g
ICC=DCC(J+K) = $6.96(0.1960+0.1076)=$2.11
Rate = (DCC + ICC)M = ($6.96+$2.11)(1.16) = $10.52

4. Supported Employment Individual:
Independent Provider:
DCC=(A/C)(1+E)(1+F)=($16.05/1)(1+30.28%)(1+9.59%)=$22.91
Where: A=f
ICC= (DCC)(J+K) = ($22.91)(0.0402+0.1076)=$3.39
Rate = (DCC + ICC)N = ($22.91+$3.39)(0.96) = $25.25

Agency Provider:
DCC=(A/C+H/I)(1+E)(1+F)(1+G)=($13.77/1+$17.42/9)(1+30.28%)(1+9.59%)(1+9.23%) =$24.50
Where: A=(0.75)(a)+(0.05)(d)+(0.20)(g)=(0.75)($13.10)+(0.05)($14.75)+(0.20)($16.05)=$13.77
ICC=DCC(J+K) = $24.50(0.1960+0.1076)=$7.44
Rate = (DCC + ICC)M = ($24.50+$7.44)(1.32) = $42.16

5. Adult Companion Services:
Independent Provider:
DCC=(A/C)(1+E)(1+F)=($11.23/1)(1+30.28%)(1+10.34%)=$16.14
Where: A=i
ICC= (DCC)(J+K) = ($16.14)(0.0402+0.1076)=$2.39
Rate = (DCC + ICC)N = ($16.14+$2.39)(0.65) = $12.04

Agency Provider:
DCC=(A/C)(1+E)(1+F)(1+G)=($11.23/1)(1+30.28%)(1+10.34%)(1+9.23%) =$17.63
Where: A=i
ICC=DCC(J+K) = $17.63(0.1960+0.1076)=$5.35
Rate = (DCC + ICC)N = ($17.63+$5.35)(0.78) = $17.92

6. Crisis Intervention:
DCC=(A/C)(1+E)(1+F)(1+G)=($22.20/1)(1+30.28%)(1+48.15%)(1+9.23%) =$46.80
Where: A=(0.25)(g)+(0.75)(h)=(0.25)($16.05)+(0.75)($40.65)=$22.20
ICC=DCC(J+K+L) = $46.80(0.1960+0.1076+0.0620)=$17.11
Rate = (DCC + ICC) = ($46.80+$17.11)= $63.91

7. Consultative Assessment Services: Set at the rate for CPT 90837 per the NE Medicaid Provider Rate Schedule (http://dhhs.ne.gov/medicaid/Documents/471-000-532-16.pdf). The rate effective July 1, 2016 for this service is $112.08 for a Licensed Mental Health Practitioner.

8. Respite:
Independent Provider – Quarter Hour:
DCC=(A/4)(1+E)(1+F)=($11.23/4)(1+30.28%)(1+1.78%)=$3.72
Where: A=i
ICC= (DCC)(J) = ($3.72)(0.0402)=$0.15
Rate = (DCC + ICC)N = ($3.72+$0.15)(0.71) = $2.75

Agency Provider – Quarter Hour:
DCC=(A/4)(1+E)(1+F)(1+G)=($11.23/4)(1+30.28%)(1+1.78%)(1+9.23%) =$4.07
Where: A=i
ICC=DCC(J) = $4.07(0.1960)=$0.80
Rate = (DCC + ICC)N = ($4.07+$0.80)(0.90) = $4.38

Independent Provider – Daily:
DCC=[(A X B)/(1/((% Time Awake/C)+(% Time Asleep/D)))] X (1+E)(1+F) =
[($11.23 X 13.0)/(1/((57.895% /1)+(42.105% /4)))+] X (1+30.28%)(1+1.78%) = $132.45
Where: A=i
ICC=DCC(J) = $132.45(0.0402)=$5.32
Rate = (DCC + ICC)N = ($132.45+$5.32)(0.80) = $110.22

Agency Provider – Daily:
DCC=[(A X B)/(1/((% Time Awake/C)+(% Time Asleep/D)))] X (1+E)(1+F)(1+G) =
[($11.23 X 13.0)/(1/((57.895% /1)+(42.105% /4)))+] X (1+30.28%)(1+1.78%)(1+9.23%) = $144.68
Where: A=i
ICC=DCC(J) = $144.68(0.1960)=$28.36
Rate = (DCC + ICC) = ($144.68+$28.36) = $173.04

Environmental Modification Assessment, Transitional Services, Assistive Technology, Vehicle Modification & Home Modifications are approved on a per case basis. Costs for services approved & service cap limits are reviewed annually.

Main 6.I. Public Input. (Continued)

DDD received comments via public forums, letters, emails and stakeholder meetings during our extensive and robust public comment period.
A variety of individuals and organizations, including consumers, parents/guardians, advocates, providers, professional associations, and other system stakeholders provided comments, which were recorded and posted on the Division's website at http://dhhs.ne.gov/developmental_disabilities/Pages/PublicComment.aspx. The spreadsheet indicates whether each individual comment led to a change in the waiver application or not, and if not, the reason for not incorporating a change. Each individual was contacted by email to acknowledge the receipt of their comment: "Thank you for your input on the proposed Home and Community Based Services waivers for adults and children with developmental disabilities. We appreciate your interest and your input will be considered prior to submission of the final applications. We are recording on a spreadsheet all public comments and the Division's responses and the spreadsheet will be posted on our website at http://dhhs.ne.gov/developmental_disabilities/Pages/PublicComment.aspx at the end of the public comment period. Again, thank you for your interest in these very important services and supports for individuals with developmental disabilities."

In total, 116 individuals/organizations submitted comments during the official public comment period that ran from December 23, 2016 to January 24, 2017. Comments were received via chat option during

the January 3, 2017 WedEx meeting, via e-mail address posted on public webpage, letters attached to e-mails or mailed to address posted on public webpage, and verbally and in writing at the January 24, 2017 public comment meeting. Trends observed in the comments are described below:

• 32 included comments about education, training, and experience requirements for independent providers that provide habilitative services. Comments were partially adopted, and as a result, clarifying language was added to the provider specifications in Appendix C of the 0394 and 4154 waivers. Comments related to lowering the qualifications were not adopted because the state did not want to compromise on participant health and safety.
• 22 included general concerns about the provider rates and how the rates for agency providers were determined, specifically the administrative costs and direct professional support staff wages. Reference to Appendix I-2-a was provided and intent of the Provider Rate Reform Initiative, already begun, was provided. These concerns did not require changes in the waiver and therefore were not adopted.
• 6 included comments not directly related to the waiver renewal, rather were asking about the eligibility determination process and services for specific individuals. Personal contact was made with the parties and no changes were made in the waiver. These comments did not require a change in the waiver and were not adopted.
• 5 included comments related to the format of the waiver application, specifically that the applications be shorter and reader-friendly. Personal contact was made with them to provide the date and time of the January 24, 2017 public comment meeting. A verbal overview and slide deck of each appendix was presented and the parties provided comments on January 24, 2017. Personal contact was made to follow up on their concerns and no changes were made to the waiver, as the format of the waiver application cannot be changed.
• 5 included concerns regarding individual budget amounts and how the budgets were determined. Responded that individual budget amounts would not change and that a participant's funding is determined through an objective assessment process which includes using the ICAP to assess a person's needs. The funding levels did not change, rather, the eleven levels were combined into four rate tiers. New ICAPs are being completed for individuals in Risk services so that participants may utilize their funding to choose unbundled services. In the near future, new ICAPs will be completed for all participants on a regular two year cycle to continually match the participant's funding to the participant's changing needs. The concerns were not adopted because the process for determination of the individual budget amounts did not change, and no changes were made in the waiver.
• 6 included comments related to the unbundling of services, specifically elimination of Community Living and Day Supports service and Medical Risk service. The State provided rationale for unbundling services, including CMS expectation for unbundling services, expanded service options and greater provider selection. No changes were made in the waiver and the comments were not adopted because unbundling services is a CMS requirement.
• 8 included concerns about elimination of workshops that would force participants into service selections in which they may feel uncomfortable, unsafe, or unwanted. Provided overview of HCBS Settings rule and opportunity for providers to repurpose buildings and services into inclusive community resources. No changes were made to the waiver and the comments were not adopted because the state has determined that workshops will not be allowed after March 2019.
• 5 included comments on the use and monitoring of PRN medications and the training requirements for Medication Aides. Comments related to the training requirements for Medication Aides were adopted, and clarifying language was added in Appendix G-2-a-I and Appendix G-3-b-ii. Comments related to the use of monitoring of PRN meds were not adopted because the state determined that providers should not be reviewing and approving the use of PRN medications. This is determined by the participant's medical practitioner.
• 5 included comments regarding transportation rates, availability of transportation in rural areas, and annual cap for transportation. Responded that the rates for DD transportation are the established Medicaid rates for transportation and were set by the Division of Medicaid and Long-Term Care. Referenced definition which allows for a critical health or safety service request that exceeds the annual cap, and provided intent of Rebase Project that has already been initiated. The comments were not adopted and no changes were made in the waiver because the rates are in line with rates offered under other DHHS programs and in accordance with state statute. The concern for the annual cap for transportation was not adopted and no change was made in the cap because data for separating out the cost of transportation was not available.
• 2 included questions from providers at the January 24, 2017 public meeting about the temporary 5606 service code and payment for services provided when participant has exceeded 15 leave days. Provider was referred to billing guidelines previously sent to all providers and posted on website. The temporary billing code for day services provided by residential providers will cease upon approval of the waivers, and there is no additional payment for participant leave days. No changes were made to the waiver and the comments were not adopted as the responses did not require changes to the description of billing methods in the waiver.
• 2 included concerns about responsibilities and capacity of Vocational Rehabiltation services and how that impacts participants leaving the educational service. DDD provided information on collaborative efforts with VR which include education/training opportunities, referral, assessment, and individualized planning. The comments were not adopted and no changes were made to the waiver. The collaboration with VR is a result of changes in the Workforce Innovation and Opportunity Act and does not require a change in the waiver.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Division of Developmental Disabilities
   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   a) The functions performed by the Division of Developmental Disabilities (DDD):
   DDD performs participant waiver enrollment activities; management of approved limits; monitoring of expenditures; level of care evaluations; review of participant service plans; prior authorization of waiver services; utilization management; establishment of statewide rate methodology; establishment of rules, policies, and procedures governing the waiver program; and quality improvement activities. A provider enrollment broker performs enrollment of qualified providers and executes Medicaid provider agreements under the oversight of the Division of Medicaid and Long Term Care, within DHHS, which is the Medicaid agency.

   b)The document utilized to outline the roles and responsibilities related to waiver operation:
   The Nebraska State Medicaid Plan Section A1-A3, approved March 6, 2014, effective Jan 1, 2014. (NE13-0030-MM4)outlines designation and authority.

   c)The methods that are employed by the designated State Medicaid Director in the oversight of these activities:
   The State Medicaid Director is the Director of the Division of Medicaid and Long Term Care (DMLTC) within the Department of Health and Human Services (DHHS). Oversight is a collaborative effort among designated staff within DMLTC and DDD. Designated Administrators from DMLTC and DDD have regularly scheduled monthly meetings to review discovered and/or anticipated issues; direct remediation and/or proactive activities; and strategically plan for collaborative alignment of Nebraska's HCBS waivers.

   Oversight methods include but are not limited to: reviewing reports of provider non-compliance and coordinating corrective action measures with DDD and Division of Public Health (DPH) as necessary and appropriate; preparing or reviewing statistical and financial data for CMS reports in collaboration with DDD and financial services staff; attending the quarterly DDD Quality Improvement (QI) Committee meetings as an active participating member; meeting with DDD staff to review program and client issues as necessary and appropriate; weekly tracking the use of Medicaid funding on the use of waiver funding relative to the budgeted amounts; and monthly monitoring expenditures and budget projections; reviewing the development, renewal, or amendments of HCBS waivers, with final approval and electronic submittal authority; reviewing the cost neutrality formulas developed in collaboration with DDD and financial services staff; and submitting claims quarterly for federal funds for allowable activities administered or supervised by DDD.

The frequency of the oversight is related to the oversight activity or collaborative projects and tasks, and ranges from monthly budget activities to annual reporting activities.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   A provider enrollment broker is the contracted entity that performs 1) Qualified provider enrollment and 2) Execution of the Medicaid Provider Agreement. In conjunction with designated DHHS staff, and within established timeframes, the provider enrollment broker electronically enrolls prospective independent and agency providers, conducts first-time or annual background checks, provides on-line and phone enrollment assistance to prospective providers, provides notice to the provider of approval or denial, and completes 5-year revalidation of provider status. The provider enrollment broker does not complete wage negotiation with the provider.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
   Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

   Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The DHHS Division of Medicaid and Long Term Care is responsible for assessing the performance of the contracted provider enrollment broker.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The provider enrollment broker submits monthly reports to the MLTC Data Analytics Team. The Data Analytics Team in Medicaid reviews the information supplied by the broker to compare data against contract deliverables. The data, such as a monthly average days to enrollment is utilized to address sub-assurances as well as for internal reports to DHHS administration and the Governor's dashboard.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☐
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐
Utilization management	☑	☐
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1. Number and percent of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements. Numerator = Number of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements; Denominator = Number of setting assessments completed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Setting Review Tool

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. Number and percent of assigned quality assurance reviews completed quarterly by the operating agency (Division of Developmental Disabilities) within the State Medicaid agency. Numerator = number of quarterly quality assurance reviews completed by operating agency; Denominator = number of quarterly quality assurance reviews assigned to operating agency.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Setting Review Tool

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
3. Number and percent of initial DD provider applications that the provider enrollment broker screened. Numerator=number of initial background check completed on DD providers Denominator=number of requested initial background checks on DD providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data Base

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

4. Number and of annual DD provider applications that the provider enrollment broker screened. Numerator =number of annual background check completed on DD providers. Denominator =number of requested annual background checks on DD providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data Base

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Nebraska's population centers are clustered in the eastern portion of the state and the distribution of waiver openings and execution of provider agreements reflect the disproportionate distribution of the population. Therefore, the State does not measure the uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver and does not measure equitable distribution of waiver openings in all geographic areas.

Quarterly off-site file reviews are conducted by DDD program accuracy staff (PAS). The sample size for this review is determined by 1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR 2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4. This second level review by DDD program accuracy staff is conducted on a sample of files to ensure activities are being applied correctly, and that reviews and remediation activities are completed as assigned. PAS are responsible for reporting all individual problems requiring remediation identified during discovery processes to supervisory staff. This information is summarized and reviewed by the DDD QIC quarterly.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local service coordination level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes show review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

The QIC receives reports and information and provides/shares feedback and support to the service districts. The MLTC representative verbally reports activities of the QIC to his/her administrator and/or the Medicaid Director and makes all meeting minutes and reports available for his/her review.

The QIC minutes show review of results, recommendations for remediation, and follow-up of recommendations or assigned tasks to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future. A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The participant's DDD Service Coordinator (SC) or Community Coordination Specialist (CCS) has primary responsibility for discovery and remediation of individual problems. Discovery processes include: monitoring; conducting supervisory file reviews; reviewing incidents; and following up on complaints.

Service coordination staff, which is the SC or CCS is responsible for in-person, on-site monitoring of individual health and welfare and monitoring of the implementation of the service plan. Service Coordination staff also monitors to ensure that an individual resides and/or receives services in a setting that meets the HCB regulations and requirements. Please see Appendix D QI-b-i for additional information on monitoring and methods of correction.

By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. When providers report alleged abuse and neglect of participants that is not required to be reported by law, the Protection and Safety staff share this information with DDD within 24 hours of receipt. DDD staff triages/reviews the information and makes a determination whether to do a complaint investigation or handle it in another manner.

The database for incidents is a web-based service system used for incident reporting and case management and the database allows DDD to review and aggregate data in various formats. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on a participant and provider wide level to address the issue and to decrease

the likelihood of future incidents. A summary of all the incidents and of the providers efforts are compiled into a report reviewed quarterly by the QIC. The QIC determines the need for systemic follow-up and additional areas requiring probing and/or DDD management intervention.

All participant grievances/complaints are reviewed and responded to within 24 working hours and logged using a system maintained by DDD. The DDD Director or designee will work with the appropriate groups to address the grievance/complaint. Complaints, questions or concerns are either responded to directly by DDD or referred to the Licensing Unit at the Department of Health and Human Services Division of Public Health, if appropriate.

As part of their discovery processes, all SC supervisors are required to conduct a review of services coordination activities on an on-going basis as outlined in the approved DDD operational guidelines. These reviews ensure that all service coordination activities are being applied correctly. The review responses are documented in an electronic data system. Indicators that do not meet standards require remediation/supervisory follow-up. Because all monitoring forms are stored in the DDD electronic records system, SC Supervisors are able to, and do, conduct regular and routine trend analysis of monitoring data. Threshold concerns are reviewed with the local DDD Field Office Administrator and brought to the attention of DDD Central Office Field Operations Administrator as needed. This information is summarized and reviewed by the DDD QIC quarterly. The summarized data for the service plan review are also shared with service coordination staff at the local service coordination level and the DSSs. The implementation data summary is shared with Service Coordination, providers and DDD Central Office staff.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☑	**Autism**	21		☑
	☑	**Developmental Disability**	21		☑
	☑	**Intellectual Disability**	21		☑
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

No additional criteria

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:
  - ( ) **Other**

    Specify:
- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:
    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - ( ) **The following percentage that is less than 100% of the institutional average:**

    Specify percent:
  - ( ) **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

  Specify the procedures for authorizing additional services, including the amount that may be authorized:
- [ ] **Other safeguard(s)**

  Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1055
Year 2	

Waiver Year	Unduplicated Number of Participants
	1055
Year 3	1055
Year 4	1055
Year 5	1055

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	900
Year 2	900
Year 3	900
Year 4	900
Year 5	900

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Transition of Individuals from Other Waivers	
Emergency	
Transitioning Youth from Special Education services.	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transition of Individuals from Other Waivers

Purpose *(describe):*

Capacity is reserved to accommodate the transition of participants from other HCBS 1915(c) waivers. The purpose is to ensure waiver capacity is available to support eligible participant's choice in waiver and services that support their employment and community integration.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Emergency

Purpose *(describe):*

Capacity is reserved for emergency purposes to support individuals in immediate crisis due to caregiver death, homelessness or other situations that threaten the life and safety of the individual.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	

Waiver Year	Capacity Reserved
	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transitioning Youth from Special Education services.

Purpose *(describe):*

Capacity is reserved for Nebraska high school graduates and supports participants who, on or after September 6, 1993, graduated from Nebraska public and/or nonpublic high school transition services and have reached the age of 21. This category of reserve capacity ensures a participant is transferred seamlessly from services offered by the public school system to day and vocational services offered by the Division of Developmental Disabilities. The purpose is to transition the most vulnerable eligible young adults from the education system into the adult developmental disabilities system to prevent loss of skills and abilities and to support employment and community integration before skills become dormant.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and approval of funding by the Nebraska legislature.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Persons who meet eligibility criteria as defined in Nebr. Rev. St. 83-1205 will be assessed for waiver and financial eligibility and placed on a wait list. The date used to establish a person's placement on the waiting list is the date of application from which eligibility for developmental disabilities in Nebraska was originally established. Persons remain on the waiting list until a waiver slot has been assigned to them for use, the Legislature appropriates special funds to serve a specific class of people, they withdraw from the list, or they become ineligible for the waiver. Waiver dollars are not used for the assessments that are done prior to placing an individual on the waiting list.

If there is a change in a person's need they may contact the Division of Developmental Disabilities and request that an assessment of an emergency situation be completed. Persons who meet an emergency situation shall be prioritized highest on the waiting list. An emergency situation is an immediate crisis due to caregiver death, homelessness or other situations that threaten the life and safety of the individual and the emergency cannot be resolved in another way. Emergencies are defined by the following criteria:
1. Homelessness: the person does not have a place to live or is in imminent danger of losing their home and has no resources/money to secure housing.
2. Abusive or neglectful situation: the person is experiencing or is in imminent risk of physical, sexual or emotional abuse or neglect in the person's present living situation.
3. Danger to self or others: the person's behavioral challenge is such that the person is seriously injuring/harming self or others in their home, or is in imminent danger of doing so.
4. Loss of primary relative caretaker due to caretaker death or the caretaker is in need of long term services and support themselves.

Once the maximum number of unduplicated participants is reached in each waiver year, no additional participants will be enrolled.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ( ) **§1634 State**
   - (●) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ◉ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- ☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☑ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Non-Magi
• State Supp (435.130)

Magi
• Pregnant Women (435.116)
• Parent/Caretaker Relative (435.110)
• Former Foster Care Children (435.150)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- ☐ **A special income level equal to:**

Select one:

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

* Recipients eligible under 1902(a)(10)(A)(ii)(XI) of the Act
• Recipients eligible under 1902(a)(10)(A)(ii)(XV) of the Act

* Recipients who are medically needy with spenddown: The State will use the actual maximum monthly allowable ICF/ID rate to reduce an individual's income to an amount at or below the medically needs income limit (MNIL) for persons who are medically needy with a Share of Cost.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- ☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

◉ **A percentage of the Federal poverty level**

Specify percentage: 100

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:
- **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage: 100
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

  Specify formula:
- **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- ( ) **The provision of waiver services at least monthly**
- (●) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

The minimum frequency for the provision of the waiver service is sixty days.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Disability Services Specialists (DSSs) employed by the Division of Developmental Disabilities (DDD), performing initial evaluations of individuals' level of care for initial waiver are professionals who have knowledge of 1) developmental disabilities (including but not limited to specific disabilities and criteria for meeting ICF-IDD Level of Care), child growth and development, observations, and assessments to include those that measure adaptive functioning. In order to perform initial evaluations for level of care, the DSSs are required to have a Bachelor's Degree in psychology, social work, education, public administration or a related human service field and one year experience working in the field of developmental disabilities. The following skills are required: Communicate effectively in a variety of situations; develop working relationships with individuals with DD, their families, review team members, community professionals, program directors, agency

representatives, and other groups of individuals with interests in DD; analyze behavioral data and formulate habilitation plans; and plan and organize habilitative training programs, interviewing techniques, assessing skills, abilities, preferences, and needs and explaining services to individuals, families, and guardians are required. Experience in working with people with DD and knowledge of quality assurance/improvement is preferred, but is not a requirement.

They must have knowledge of current practices in the field of DD, including service coordination, program planning, disability law, medications, the theory of social role valorization, and provision of habilitation services.

The Disability Services Specialists receive quarterly in-service training on assessment(s), evaluation, level of care determination, and waiver eligibility

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Individuals who are deemed to require ICF-IDD level of care are enrolled in and maintained on (pursuant to reevaluation) this waiver. All waiver participants must meet the criteria for a developmental disability as defined under Neb. Rev. Stat. § 83-1205:
Developmental disability shall mean a severe, chronic disability, including an intellectual disability, other than mental illness, which:
(1) Is attributable to a mental or physical impairment unless the impairment is solely attributable to a severe emotional disturbance or persistent mental illness;
(2) Is manifested before the age of twenty-two years;
(3) Is likely to continue indefinitely;
(4) Results in substantial functional limitations in one of each of the following areas of adaptive functioning:
(a) Conceptual skills, including language, literacy, money, time, number concepts, and self-direction;
(b) Social skills, including interpersonal skills, social responsibility, self-esteem, gullibility, wariness, social problem solving, and the ability to follow laws and rules and to avoid being victimized; and
(c) Practical skills, including activities of daily living, personal care, occupational skills, healthcare, mobility, and the capacity for independent living; and
(5) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.
An individual from birth through the age of nine years inclusive who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the major life activities described in subdivision (4) of this section if the individual, without services and support, has a high probability of meeting those criteria later in life.

The following the level of care criteria is used to initially evaluate whether an individual needs services through the waiver:
a. Eligibility status as defined under Neb. Rev. Stat. § 83-1205, which is verified at ages 9 and 18;
b. Medicaid eligibility status;
c. Service plan (Individual Support Plan - ISP);
d. Developmental Index ICF-IDD Level of Care assessment; and
e. Signed form for request/consent to community based services, which is the choice between home and community based waiver services and ICF-IDD services and choice of providers.

The following criteria is used to annually evaluate whether an individual needs services through the waiver:
a. Eligibility status as defined under Neb. Rev. Stat. § 83-1205;
b. Medicaid eligibility status;
c. Service plan (Individual Support Plan - ISP); and
d. Developmental Index ICF-IDD Level of Care assessment.

For all waiver participants, the above criteria for a developmental disability as defined under Neb. Rev. Stat. § 83-1205 is verified at ages 9 and age 18.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The Developmental Index LOC assessment tool for waiver evaluation and reevaluation is comparable to the ICF/DD Utilization Review assessment tool completed for institutional ICF placement. Both tools note skills, abilities, preferences, and needs, including health needs, means of communication, and behavioral concerns. The participant and family or guardian, and their service coordinator (SC)/Community Coordinator Specialist (CCS), provider staff, or others who are familiar with the participant complete the applicable tool.

The Developmental Index, the waiver LOC assessment tool, differs from the ICF/DD Utilization Review, the ICF LOC assessment tool, by assessing skills, abilities, and areas needing improvement for maximizing independence in the community, such as job-readiness, managing personal finances, and accessing community services. The Developmental Index LOC assessment is completed on an annual basis. Although the tools are different, reliability and validity testing using a sampling methodology indicates that the outcome of the determinations yielded from the Developmental Index is similar to the outcome of determinations yielded from the assessment completed for ICF placement.

If a former waiver participant enters the State ICF for short-term intensive behavioral treatment, the LOC is determined using the ICF/DD Utilization Review assessment tool.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

DDD requires that an initial and an annual reevaluation of waiver eligibility are conducted to access waiver services. The DSSs perform the initial waiver approval, as stated in Section B-6 d. A determination of initial waiver eligibility is made within ten business days of the DSS receiving notification from the SC/CCS that a participant is ready for entrance to the waiver.

SCs/CCSs perform the annual waiver level of care review. The process for the annual waiver review by the SC/CCS includes a review eligibility status as defined under Neb. Rev. Stat. § 83-1205; of the Developmental Index/Level of Care Assessment; Individual Support Plan (ISP); and Medicaid eligibility status.

The Developmental Index/Level of Care Assessment is completed by the participant, their SC/CCS, provider staff, and other team members at the ISP meeting. This process allows all team members to have and provide input. Within ten business days, the annual reevaluation is completed and the participant's annual budget is approved and authorized by the Service Coordination Supervisor in accordance with policy and state and federal regulations.

As a last step, the SC/CCS provides notification of eligibility for annual waiver services to the participant and/or representative. If eligible, the participant is maintained on the waiver. If the participant is not eligible because they are not Medicaid eligible or do not meet ICF-IDD Level of Care for waiver, these participants are removed from the waiver and their waiver case is closed. Participants who are determined not eligible for waiver services receive written notification of their ineligibility via a Notice of Decision and are then eligible for a Fair Hearing under the state regulations if they believe that the eligibility determination was made in error or the Level of Care determination is not accurate.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**

Specify the qualifications:

The qualifications of a SC are as follows:

1. Bachelor's Degree required in: education, psychology, social work, sociology, or human services, or a related field and experience in services or programs for persons with intellectual or other developmental disabilities.
2. Ability to: mobilize resources to meet individual needs; communicate effectively to exchange information; develop working relationships with individuals with intellectual or developmental

disabilities, their families, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; monitor services and supports provided; apply Department of Health and Human Services (DHHS) and program rules, policies, and procedures; and organize, evaluate and address program/operational data.
3. Knowledge of: current practices in the field of community-based services for persons with intellectual disabilities and other developmental disabilities; person-centered planning; Americans with Disability Act (ADA) standards; self-direction; community integration; the principles of social role valorization; provision of habilitation services; positive behavioral supports; and, statutes and regulations pertaining to delivery of services for individuals with developmental disabilities.
4. Knowledge of: the program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities (DDD); regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; State statutes regarding persons with disabilities; and DHHS programs, such as Protection and Safety and public assistance programs.

The qualifications of a CCS are as follows:

1. Bachelor's degree and professional experience are required in: education, psychology, social work, sociology, human services, or a related field.
2. Ability to: mobilize resources to meet individual needs; communicate effectively to exchange information; develop working relationships with individuals with intellectual or developmental disabilities, their families, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; monitor services and supports provided; apply Department of Health and Human Services (DHHS) and program rules, policies, and procedures; and organize, evaluate and address program/operational data.
3. Ability to: assess the needs of persons with intellectual or other developmental disabilities; evaluate assessments; determine eligibility of individuals; develop and assess individual program plans and individual family support plans; adjust services as needed; mobilize resources to meet individual needs; interact and communicate with federal surveyors, other regulatory bodies and others in person via telephone, electronically, and written correspondence to exchange information and to respond to information requests; report non-compliance to appropriate agencies; develop working relationships with individuals with intellectual or developmental disabilities, their families and guardians, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; conduct formal assessments; monitor services provided; apply agency and program rules, policies, and procedures; think critically; and, organize, prioritize, evaluate and address program/operational data.
4. Knowledge of: current practices in the field of community-based services for persons with intellectual disabilities and other services for persons with developmental disabilities; person-centered program planning; basic medical terminology; the principles of social role valorization; provision of habilitation services; and positive behavioral support techniques.
5. Knowledge of: the program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities; regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; State statutes regarding persons with disabilities; and DHHS programs, such as Protection and Safety and public assistance programs.

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The SCs/CCSs utilize the web-based case management system and the processes within it that are components of case management to ensure timely reevaluations of level of care. SC/CCS Supervisors run electronic reports to determine if reevaluations are conducted timely and review findings with SCs/CCSs at monthly supervision meetings.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The state assures that written and/or electronically retrievable documentation of all evaluations for initial waiver and reevaluations for annual waiver are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Disability Service Specialists who are responsible for the level of care evaluations, initial waiver review and approval maintain an electronic record for each waiver participant. SC/CCS staff who are responsible for performing the annual waiver review also keep an electronic record for each participant. The electronic records are maintained in SharePoint and the web-based case management system permanently.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new waiver eligible applicants for whom Intermediate Care Facility (ICF) Level of Care (LOC) was determined prior to the receipt of services. Numerator = number of new waiver eligible applicants for whom ICF LOC was determined prior to receipt of services; Denominator = number of new waiver eligible applicants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of Level of Care (LOC) determinations reviewed in which LOC criteria were accurately applied. Numerator = number of initial and annual LOC determinations reviewed in which LOC criteria were accurately applied. Denominator = number of initial and annual LOC determinations reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of participants for whom initial or annual Level of Care (LOC) that are not revised as a result of appeals. Numerator = number of LOC determinations are not revised as a result of appeals. Denominator = number of total number of LOC determinations for the entire waiver.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Annual reevaluation of waiver eligibility is completed for all (100%) waiver participants. Completion of the Developmental Index LOC assessment is completed during the participant's annual ISP meeting and documented in the ISP. Quarterly reviews for renewals are conducted by Service Coordination Supervisors.
Additionally, DDD Central Office Program Accuracy Specialists (PAS) or Quality Assurance Control Specialists (QASQCS) will conduct annual off-site file reviews to verify the work of the Disability Service Specialists and Service Coordinator Supervisors. The percentage of off-site and on-site file reviews will be included in the State's internal HCBS Waiver quality improvement off-site and on-site review processes. Those processes will be reviewed annually to ensure the combined percentage of files reviewed represents a sample size that has a confidence level of 95% with a +/- 5% margin of error. The sample size for this review is determined by 1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR 2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state monitors level of care (LOC) evaluations and reevaluations, and takes action to address individual problems that are discovered, which may include failure to complete LOC evaluations/reevaluations, failure to follow established timelines, inaccurate determinations, and missing or incomplete documentation.

The disability services specialists' (DSS) Supervisor evaluates the performance of the DSS staff, utilizing the electronic quality assurance data for identification of technical assistance/training needs for individual and/or all DSSs, as well as for identification of systems changes. Given that each initial eligibility determination is vetted by the DSS Supervisor prior to a final decision being made, quality assurance review is continuous and ongoing at the 100% threshold.

Monthly quality assurance reports are reviewed at both the field office and central office levels to ensure continued Medicaid and waiver eligibility for participants. The monthly quality assurance reports are electronically generated for access by DDD staff. DSSs, SC/CCSs, and Supervisors review reports for their caseload and take appropriate action as needed on individual cases. Examples of such action may be assisting the staff person with recertification of Medicaid, correcting a service authorization to change or end waiver services, completing a LOC assessment, etc.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Nebraska waiver participants are afforded choice among waiver services as well as between waiver services and institutional care and this information is provided by the participant's Service Coordinator or Community Coordinator Specialist. Information about Nebraska's DD waiver services, feasible alternatives, and freedom of choice is provided verbally and in written materials to assist the individual or legal representative in understanding waiver services, funding of his/her services, and the roles and responsibilities of the participants (the individual, family, guardian, DHHS staff, etc.). Choice of ICF or waiver services is documented on Form DDD-1. Form DDD-1 explains the right and process to appeal.

A signature for consent, documenting that waiver participant's choice is to receive community based waiver services over services in an institutional setting, is obtained upon initial determination of waiver eligibility and is kept in the participant's electronic waiver file. If guardianship or legal status changes, service coordination must obtain a new, signed consent.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Form DDD-1, the waiver consent form, is kept in the participant's waiver file maintained by the Disability Services Specialist. The records are maintained permanently in electronic files by Division staff.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The following methods are utilized to provide meaningful access to services by individuals with limited English proficiency at entrance to waiver services and on an ongoing basis;
• Oral language assistance services such as interpreters;
• Spanish translation of written materials, such as applications, brochures, due process, and the Notice of Decision;
• Spanish language placards, posters, etc.;
• Second language hiring qualifications;
• Availability of translators, including sign language;
• AT&T statewide language line; and
• Spanish language web sites.

Based on a published table of Estimate of at Least Top 15 Languages Spoken by Individuals with Limited English Proficiency (LEP) for the 50 States, the District of Columbia, Puerto Rico and each U.S. Territory from the U.S. Department of Health and Human Services, Office for Civil Rights, August 2016, Spanish is the prevalent non-English language in Nebraska. When the primary language is not English or Spanish, the state provides timely and accurate language assistance services, such as oral interpretation, and written translation when written translation is a reasonable step to provide meaningful access to an individual with LEP.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment - Individual**		
Other Service	**Adult Companion Service**		
Other Service	**Adult Day Services**		
Other Service	**Assistive Technology**		
Other Service	**Behavioral Risk Services**		
Other Service	**Community Living and Day Supports**		
Other Service	**Consultative Assessment Service**		
Other Service	**Crisis Intervention Support**		
Other Service	**Environmental Modification Assessment**		
Other Service	**Habilitative Community Inclusion**		
Other Service	**Habilitative Workshop**		
Other Service	**Home Modification**		

Service Type	Service		
Other Service	Integrated Community Employment		
Other Service	Medical Risk Services		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Retirement Services		
Other Service	Supported Employment - Enclave		
Other Service	Supported Employment - Follow Along		
Other Service	Team Behavioral Consultation		
Other Service	Transitional Services		
Other Service	Transportation		
Other Service	Vehicle Modification		
Other Service	Vocational Planning Habilitation Service		
Other Service	Workstation Habilitation Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Day Habilitation services are formalized training and staff supports that take place in a non-residential setting separate from the participant's private residence or other residential living arrangement. Day Habilitation services are scheduled activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, and community living. Day Habilitation services may be provided to participants that do not have a clear plan for employment and are therefore not currently seeking to join the general work force. Training activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice necessary to participate successfully in community living. Participants receiving day habilitation services are integrated into the community to the greatest extent possible.

Day Habilitation may be delivered in integrated community settings or in provider owned and operated settings for a portion of the typical workday. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in a participant's service plan. Staff support is continuous, that is, staff are present at all times the participant is present. Continuous day services are expected to be available for no less than seven hours per day. The provider may operate a location where participants come to check-in prior to participating in integrated activities and/or to participate in a variety of daily activities related to greater community living. Provider owned and controlled settings also allow for participants who are experiencing short-term medical or behavioral crisis to participate in activities that are outside the residence.

Habilitation, or teaching and supporting, may include teaching such concepts as self-direction, attendance, task completion, problem solving, and safety. Services are generally not job-task oriented but instead are directed at improvement of basic skills such as attention span and motor skills, and not explicit employment objectives.

The activities, services, supports, and strategies are documented in the service plan, and the frequency and duration for which the services are delivered will be based on the service plan. Day Habilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies listed in the service plan. In addition, the services and supports may reinforce skills taught in therapy, counseling sessions, or other settings. This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the participant, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.

Transportation may be provided between the participant's place of residence and the habilitation (teaching and supporting) service site or between habilitation service sites (in cases where the participant receives habilitation) services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services. The cost of transportation between other habilitation sites should be billed under those waiver services and not this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Day Habilitation services offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Day Habilitation services and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

For participants with degenerative conditions, these services may include training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Meals provided as part of these services do not constitute a full nutritional regiment and as applicable, physical nutritional management plans must be implemented as documented in the service plan. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Participants that choose Day Habilitation services may also receive Community Living and Day Supports (CLDS) but these services may not be billed during the same period of the day. Daily rates are available for Day Habilitation services when the participant receives this service for four or more hours. Hourly rates are also available for times when the participant might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate. CLDS can only be billed at an hourly rate on days when no daily rate is billed for Day Habilitation. When both services are provided in one workday, both Day Habilitation services and CLDS are billed in hours.

The amount of authorized services is the participant's approved annual budget and is provided based on the participant's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify)*:
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificates of completion from an accredited source, when applicable or upon request:
  o Abuse, neglect, exploitation, and state law reporting requirements and prevention;
  o Cardiopulmonary resuscitation; and
  o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):
Prevocational Services

HCBS Taxonomy:

Category 1:
04 Day Services
Sub-Category 1:
04010 prevocational services
Category 2:
Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Prevocational Services are habilitative services that provide learning and work experiences, including career planning, job searching, and work experiences, where the participant can develop general, non-job-task-specific strengths and skills that contribute to future employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the participant and his/her service and team through an ongoing person-centered planning process. Prevocational service habilitative activities must be reflected in the participant's service plan. Services may be furnished in a variety of locations in the community.

Participants receiving prevocational services must have employment-related goals in their service plan; the general habilitation activities must be designed to support such employment goals. To be considered to be a successful outcome of prevocational services, the participant will obtain the opportunity for competitive, integrated employment in the community. Prevocational Services may include career planning to prepare the participant for, obtain, maintain or advance employment. Services with focus on career planning includes development of self-awareness and assessment of skills, abilities, and needs for self-identifying career goals and direction, including resume or business plan development for customized home businesses. Prevocational services may involve assisting the participant in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

Prevocational Services may be provided on either an individual or a small group basis by individual providers and to individuals, small groups and large groups by agency providers based on the participant's assessed needs. For those whose service is normally billed as part of a group, time spent conducting job searches for an individual may be billed at the individual rate. This time may not be billed for the same time period a group rate is billed.

Prevocational Services may include job searching designed to assist the participant (or in limited situations on behalf of the participant), to locate a job or development of a work experience. Job searching with the participant will be provided on a one to one basis to achieve the outcome of this service. For those who otherwise receive their services in a group, providers should bill for job searches at the individual rate.

Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training. Prevocational services also includes the provision of personal care and protective oversight and supervision (when applicable) to the participant.

Participation in Prevocational Services is not a required pre-requisite for Supported Employment- Individual or Supported Employment-Enclave services provided under the waiver.

Prevocational Services may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• This service may be authorized in combination with any, or all, of the following services in the same service plan, but not during the same time period: Adult Day Services, Supported Employment (Individual, Enclave, and Follow-Along), Habilitative Community Inclusion, and/or Habilitative Workshop. The total combined hours for these services may not exceed a weekly amount of 35 hours.
• Prevocational services are time-limited and should not exceed 12 consecutive months. In some cases, an additional 12 months may be approved by the Division in subsequent years with submission of an approved employment plan (through vocational rehabilitation, school district, or the waiver) and upon review of active progress made the prior year on finding employment opportunities, increasing work skills, time on tasks, or other job preparedness objectives.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• The service is reimbursed at an hourly unit.
• Transportation to and from the participant's private residence, or other provider setting, to the Prevocational service is not included in the reimbursement rate.
• Prevocational service shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan, HCBS Waiver services, or Vocational Rehabilitation.
• Effective March 1, 2017, documentation for any supported employment service must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).
• Prevocational Services may be provided by a relative but not a legally responsible individual or guardian.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency
Individual	independent Individual - Habilitative Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian;
• Not be an employee of DHHS; and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Individual

Provider Type:
independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
No certification is required.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Have necessary education and experience, and provide evidence upon request:
o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
o Have any combination of education and experience identified above equaling four years or more;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):
Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite service is a non-habilitative service that is provided to participants unable to care for themselves and is furnished on a short-term, temporary basis for relief to the usual caregiver(s) living in the same private residence as the participant. Respite includes assistance with activities of daily living (ADL), health maintenance, and supervision.

Respite services may be provided in the caregiver's home, the provider's home or in community settings.

Respite services may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Respite service is reimbursed at a 15 minute unit or daily rate. Respite services provided in a facility setting not operated by a DD provider and approved by the Division must be reimbursed at the facility's daily rate and can only be used when all other provider options for respite are exhausted. Hourly rates are not available in non-DD facilities that provide respite because the non-DD Medicaid facilities have a per diem rate.
• Any use of respite over 9 hours within a 24-hour period must be billed as a daily rate. Use of respite under 9 hours must be billed in 15 minute units. Use of the 9 hours or total amount of 15 minute units count as actual time towards the available 240 hours per year.

• Federal financial participation is not to be claimed for the cost of room and board except when provided as a part of respite care furnished in a facility approved by the Division that is not a private residence.
• The maximum number of hours for participants is 240 hours per annual budget year and cannot be carried over into the next annual budget year.
• Transportation from the participant's private residence to a provider's home or community setting is not included in the reimbursement rate.
• Respite services may not be provided during the same time period as other HCBS waiver services.
• Respite Services may not be provided by any individual provider that lives in the same private residence as the participant, or is a legally responsible individual or guardian of the participant.
• A Respite service provider or provider staff shall not provide respite services to adults (18 years and older) and children at the same time.
• A Respite service provider or provider staff must be 19 years of age or older to provide respite services.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Respite Care Service Agency
Individual	Independent Individual - Non-Habilitative Services
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Independent Respite Care Service Agency
Provider Qualifications
License *(specify):*
175 NAC Health Care Facilities and Services Licensure.
Certificate *(specify):*
No certificate is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:

Independent Individual - Non-Habilitative Services

Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
No certificate is required.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
DD Agency

Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian;
• Not be an employee of DHHS; and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Supported Employment - Individual

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supported Employment-Individual is the 1:1 formalized training and staff supports available to a participant who, because of their disability, needs intensive, sometimes on-going support, to obtain and maintain an individual job in competitive or customized employment, self-employment, in an integrated work setting in the general workforce for which an participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability. Support may involve assisting the participant in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning. The outcome of this service is sustained paid employment in an integrated setting in the general workforce that meets personal and career goals.

Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant and are designed to obtain, maintain or advance employment by a participant, including supervision and training. When Supported Employment - Individual is provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's service plan that supports the need for continued job coaching with a plan to lessen the job coaching. Supported Employment - Individual must be provided in a community employment setting, unless the support is to develop a customized home-based business.

Supported Employment-Individual may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• This service may be authorized in combination with any, or all, of the following services in the same service plan, but not during the same time period: Adult Day Services, Supported Employment -Enclave, Habilitative Community Inclusion, Prevocational, and/or Habilitative Workshop. The total combined hours for these services may not exceed a weekly amount of 35 hours.
• Income from customized home-based businesses are not required to be commensurate with minimum wage requirements with other employment.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• This service is reimbursed at an hourly unit.
• Transportation to and from the participant's private residence, or other provider setting, to the Supported Employment-Individual is not included in the reimbursement rate.
• This service shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan, HCBS Waiver services, or Vocational Rehabilitation.
• Effective March 1, 2017, documentation for any supported employment service must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).
• Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
o Payments that are passed through to users of supported employment programs; or
o Payments for training that is not directly related to a participant's supported employment program.
• Supported Employment-Individual may be provided by a relative but not a legally responsible individual or guardian.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency
Individual	Independent Individual - Habilitative Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and

• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:
Individual

Provider Type:
Independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
No certification is required.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Have necessary education and experience, and provide evidence upon request:
o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
o Have any combination of education and experience identified above equaling four years or more;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adult Companion Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Adult Companion Service is a drop-in, habilitative service and includes adaptive skill development, non-medical care, supervision, socialization and assisting a participant in maintaining safety in the home and enhancing independence in self-care and home living skills. Adult Companion Service is provided to the participant in their home.

Adult Companion Service assists a participant to live in a private residence (non-provider operated or controlled), when the participant requires a range of community based support to live as independently as possible. Adult Companion Service provides individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living successfully in the community.

Adult Companion Service includes prompting and supervising the participant in completing tasks including but not limited to, activities of daily living (ADL); health maintenance; meal preparation; laundry; teaching the use of police, fire, and emergency assistance; performing routine household activities to maintain a clean and safe home; and managing personal financial affairs. Adult Companion Service staff do not perform these activities for the participant.

Adult Companion Service may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Adult Companion Service cannot exceed a weekly amount of 25 hours.
• Adult Companion Service is reimbursed at an hourly unit.
• Transportation is not included in the reimbursement rate.
• Adult Companion Service shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan or HCBS Waiver services.
• Adult Companion Service may be provided by a relative but not a legally responsible individual or guardian.
• An Adult Companion Service provider or provider staff must be 19 years of age or older to provide services.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency
Individual	Independent Individual - Habilitative Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion Service

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  o Cardiopulmonary resuscitation; and
  o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian;
• Not be an employee of DHHS; and
• Possess a valid driver's license and insurance as required by Nebraska law.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion Service

Provider Category:
Individual
Provider Type:
Independent Individual - Habilitative Services
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
No certification is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Have necessary education and experience, and provide evidence upon request:
o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
o Have any combination of education and experience identified above equaling four years or more;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adult Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Adult Day Services are non-habilitative services consisting of meaningful day activities. Adult Day Services provide active supports which foster independence, encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult Day Services include assistance with activities of daily living (ADL), health maintenance, and supervision. Participants receiving Adult Day Services are integrated into the community to the greatest extent possible.

Adult Day Services are supervision and support services to keep participants who need the service in a safe, supervised setting that does not require the training goals and strategies of habilitation services. Adult Day Services do not offer as many opportunities for getting participants engaged in their community or participating in community events mainly due to compromised health issues and significant limitations of participants. Providers are not allowed to engage participant in work activities for no pay for which non-participants would be paid a wage. Engaging participants in volunteer activities is within the scope of this service.

Adult Day Services are intended to be provided in a non-residential licensed facility. The Adult Day Service provider must be within immediate proximity of the participant to allow staff to provide support and supervision, safety and security, and provide activities to keep the participant engaged in their environment.

Adult Day Services are not self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• This service may be authorized in combination with any, or all, of the following services in the same service plan, but not during the same time period: Supported Employment (Individual, Enclave, and Follow-Along), Habilitative Community Inclusion, Prevocational, and/or Habilitative Workshop. The total combined hours for these services may not exceed a weekly amount of 35 hours.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Adult Day Services are reimbursed at an hourly unit.
• Transportation to and from the participant's private residence, or other provider setting, to the Adult Day Service is not included in the reimbursement rate.
• Adult Day Services shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan or HCBS Waiver services.
• Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws.
• An Adult Day Service provider or provider staff must be 19 years of age or older to provide services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Services

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify):*
Licensure by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§ 71-401 to 71-462 - Health Care Facility Licensure Act.
Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify):*
The Adult Day provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes. The provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Division of Public Health (DPH)
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**
◉ **Service is included in approved waiver. The service specifications have been modified.**
○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Assistive Technology is equipment or a product system such as devices, controls, or appliances, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants and be necessary to ensure participants health, welfare and safety. The use of assistive technology enables participants who reside in their own homes to increase their abilities to perform activities of daily living in their home, or to perceive, control, or communicate with the environment they live in, thereby decreasing their need for assistance from others as a result of limitations due to disability.

All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation.

Assistive Technology includes the equipment or product system as well as:

a. Services consisting of purchasing or leasing assistive technology devices for participants.
b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
c. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan.
d. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant.
e. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive Technology may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Assistive Technology has a participant annual budget cap of $2,500.
• The Division may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. The Division may use a third party to assess the proposed modification and need for the modification to ensure cost effectiveness and quality of product. This assessment will be funded by the Environmental Modification Assessment service and will be reimbursed separately. The cost of the Environmental Modification Assessment is not included in the $2,500 cap on Assistive Technology.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Assistive Technology is reimbursed per item directly to vendor or provider of services.
• This service shall not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services, or Nebraska DHHS Economic Support program services.
• Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.
• For items over $500 insurance or an extended warranty is required.
• Damaged, stolen or lost items not covered by insurance or warranty may be replaced once every two years.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency - Non-Habilitative
Individual	Independent Individual - Non-Habilitative

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Independent Agency - Non-Habilitative
Provider Qualifications
License *(specify)*:
Electricians must be licensed in accordance with Neb. Rev. § 81-2106 through 2118. Plumbers must be licensed in accordance with Neb. Rev. § 18-1901 through 1919.
Certificate *(specify)*:
No certification is required.
Other Standard *(specify)*:
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements, including annual background checks;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Independent Individual - Non-Habilitative
Provider Qualifications
License *(specify)*:
As applicable, vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.
Certificate *(specify)*:
As applicable, vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.
Other Standard *(specify)*:
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavioral Risk Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Behavioral risk services are provided to participants with complex behavioral needs that require continuing care and treatment. Behavioral risk services may be required when behaviors place the participant and/or others at risk of harm and may include actual, attempted, or threatened physical harm to oneself and/or others. This includes implicit threats, which is defined as statements and/or acts that reasonably induce fear of physical harm to others. Additionally, examples of behaviors placing oneself and/or others at risk of harm include self-directed actions intended to cause tissue damage, medication non-compliance, destruction of other people's belongings, elopement, and contact with the legal system for the previously mentioned behaviors, as well as other law-breaking behaviors (e.g., stealing, vandalism).

The need for behavioral risk services will be determined by designated staff at Division of Developmental Disabilities (DDD) central office. A risk screen is completed by the participant's service plan team to assist the team in planning, as a guide in giving adequate consideration to risk factors, or at the request of DDD central office. If the risk screen indicates a participant may present a risk of harm to oneself and/or others, the participant may be referred to DD central office for a formal risk assessment.

A risk assessment identifies, evaluates, and prioritizes interventions to implement or attempt to manage/reduce risk. The risk assessment will include the following: description, likelihood, frequency, duration, intensity, imminence, and incapacitation. Additionally, it includes an examination of the function of violence, for example, perceptual distortions, antisocial attitudes, irrational beliefs, labile affect, or interpersonal stressors. A risk assessment will also evaluate "buffering" conditions that reduce the likelihood of risk, for example, residential and day habilitation (teaching and supporting) services, non-DD therapeutic services, a participant's personal strengths (e.g., motivation), support system (e.g., family and friends), ability to establish pro-social judgment, and history of adverse life events.

If DDD central office staff concludes a participant presents a moderate to high risk of harm to oneself and/or others, the participant will be eligible for behavioral risk services. Should a participant present with a dual diagnosis of DD and mental illness and their risk is a result of issues stemming from Axis I, primary diagnosis of severe persistent mental illness, then the participant will be referred for behavioral health services. Behavioral risk services are not intended to supplant other behavioral health services such as, but not limited to psychiatry, counseling, or individual or group therapy.

Behavioral risk services are provided 24/7 and are considered to be continuous services. This service is an all-inclusive daily rate service that includes residential habilitation (teaching and supporting) services, day habilitation (teaching and supporting) services, transportation, intensive behavioral supports, ongoing safety supervision, and ongoing clinical supports. Because behavioral risk services are all-inclusive, a participant cannot receive these services in combination with another DD waiver service. When behavioral risk service is delivered where the participant lives, where the participant works, where the participant is recreating and socializing, or where the participant participates in day services, the service is billed as Behavioral Risk service, and is not billed as a separate residential habilitation service or a separate day habilitation services.

The provision of behavioral risk services will be under the direction of a supervising mental health practitioner. Behavioral risk services are furnished as specified in the service plan. Staffing ratios are flexible and commensurate to meeting the needs of the participant.

Intensive behavioral intervention strategies and supports require ongoing assessment, professional judgment, and treatment based on ongoing assessment. The provider must have a licensed independent mental health practitioner on staff to oversee the delivery of behavioral risk services by unlicensed direct support professionals.

Residential habilitation (teaching and supporting) services under this service can be delivered in a variety of home settings. Residential habilitation (teaching and supporting) services delivered as an inclusive component of this service include formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. A participant cannot be authorized for another residential habilitation service and behavioral risk services at the same time. Formalized training, intensive behavioral supports, and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to his/her needs. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.

Day habilitation (teaching and supporting) services delivered as an inclusive component of this service include formalized training and staff supports which focus on the acquisition of work skills and appropriate work behavior. Day habilitation services that are provided as part of this all-inclusive service are provided in non-residential settings in the community. A participant cannot be authorized for another day habilitation service and behavioral risk services at the same time. Behavioral risk day habilitation (teaching and supporting) also includes intensive behavioral supports that focus on the behavioral and adaptive skills necessary to enable the participant to attain or maintain his or her maximum integration, inclusion, and personal accomplishment in the working community. Day habilitation (teaching and supporting) services, such as day habilitation service activities, workstations, vocational planning service, or integrated community employment are provided away from the home, in a non-residential setting, during typical working hours. Discreet habilitation (teaching and supporting) in preparation for leaving the residential setting during typical working hours is allowed.

Intervention strategies for the delivery of habilitation (teaching and supporting), intensive behavioral supports, ongoing safety supervision, and ongoing supports are determined by the service plan team in conjunction with the supervising mental health practitioner and must be documented in the service plan. Interventions will be based on the participant's assessed needs and, as

applicable, will include the following: staff objectives/ safety plans for preventing and/or stopping behaviors that are harmful to the participant or others; habilitation (teaching and supporting) to address acceptable communication of needs and preferences, coping, social, and problem-solving skills; residential and vocational settings, environmental and architectural factors, and location of service delivery; collaboration with behavioral health efforts to meet mental health needs (e.g., counseling, individual/ group psychotherapy, psychotropic medications); and supervision and monitoring strategies, including the type and amount of supervision, law enforcement contacts, provider monitoring responsibilities, and service coordination responsibilities. Restrictive interventions to ensure the safety of the participant and others must be reviewed at every service plan meeting. When applicable, a plan to reduce/eliminate the restriction must be developed, documented in the service plan, and upon request provided to DDD central office.

When determined appropriate by the service plan team and supervising practitioner, a plan to reduce the intensity of Behavioral Risk Services must be developed and upon request, provided to DDD central office.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Because Behavioral Risk service is an all-inclusive service, the cost of transportation is included in the rate paid to providers of Behavioral Risk service. The time when a participant is transported by a provider may be billed. The participant must be with the provider staff in order for transportation time to be claimed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Behavioral Risk services offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Behavioral Risk services and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

The amount of authorized services is the participant's approved annual budget and is provided based on the participant's preferences to the extent possible, and as documented in the service plan. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Risk Services

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications

License *(specify):*
Mental health practitioners require a license and must hold the license in accordance with applicable state laws.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120

Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation; and
  - Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a legally responsible individual or guardian; and
- Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Living and Day Supports

HCBS Taxonomy:

Category 1: 17 Other Services

Sub-Category 1: 17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Community Living and Day Supports (CLDS) provides the necessary assistance and supports to meet the daily needs and preferences of the participant. CLDS is provided with the participant present to ensure adequate functioning in the participant's home, as well as assisting the participant to participate in a wide range of activities outside the home. CLDS may also provide the necessary assistance and supports to meet the employment and/or day service needs of the participant in integrated, community settings.

The Community Living and Day Supports service includes the following components:
• Individual assistance with hygiene, bathing, eating, dressing, grooming, toileting, transferring, or basic first aid.
• Supervision and monitoring for the purpose of ensuring the participant's health and safety.
• Supports to enable the participant to access the community. This may include someone hired to accompany and support the participant in all types of community settings.
• Supports to assist the participant to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.
• Supports to assist the participant in identifying and sustaining a personal support network of family, friends, and associates.
• Household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry.
• Home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment.
• Supports to enable the participant to maintain or obtain employment. This may include someone hired to accompany and support the participant in an integrated work setting. Integrated settings are those considered as available to all members of the community. The employment supports are delivered informally. That is, the provider is not required to write formal training programs with long term goals, short term objectives, strategies, and data collection methodology. The supports delivered under CLDS are considered "natural teaching moments".
• Supports to enable the participant to access services and opportunities available in community settings. This may include accompanying the participant to and facilitating participation in general community activities, community volunteer work, and services provided in community settings such as senior centers and adult day centers. CLDS must not be duplicative or replace other supports available to the participant. The services provided under CLDS are different from those provided under Targeted Case Management (DD service coordination) in that the CLDS provider supports the participant by providing transportation if necessary and remaining with the participant during receipt of the services and community activities. Nebraska service coordinators do not provide direct services and supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. CLDS offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose CLDS and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

CLDS cannot be provided by the usual caregiver. The term "usual caregiver" means a person(s) who resides with the participant, is not paid to provide services, and is responsible for the care and supervision of the participant on a 24-hour basis.

Payment for CLDS does not include payments made, directly or indirectly to members of the participant's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Assistance with personal care needs or household activities is available only to those participants who live with an unpaid caregiver.

CLDS is not intended to duplicate or replace other supports available to the participant, including natural supports and state or federally funded services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Household activities and home maintenance activities are for the purpose of fulfilling duties the participant would be expected to do to contribute to the operation of the household, if it were not for the participant's disability.

Homemaker services cannot be authorized when a participant receives Community Living and Day Supports.

Routine health care supports may be furnished to the extent permitted under Nebraska state law.

Individual assistance with money management and personal finances may be provided, but the provider cannot act as the representative payee.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement and as required by law, will be examined prior to any authorization of home maintenance services under CLDS.

The participant must supply necessary cleaning products and equipment when a provider cleans or cares for household equipment, appliances, or furnishings in the participant's home.

Payment for the work performed by the staff is the responsibility of the employer. Covered services do not include those provided in specialized developmental disability provider settings, workstations, or supported employment services.

Supports provided under CLDS must be those that are above and beyond the usual services provided in such a setting and not duplicate services expected to be the responsibility of immediate household members, a senior center, adult day center, or employer. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. CLDS cannot be delivered at the same time as the delivery of Workstation Habilitation services, Day Habilitation services, Vocational Planning Habilitation services, Integrated Community Employment services, or Respite services.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Individual - Non-Habilitative Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living and Day Supports

Provider Category:
Individual
Provider Type:
Independent Individual - Non-Habilitative Services
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
No certification is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian;
• Not be an employee of DHHS; and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Consultative Assessment Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Consultative Assessment Service is provided when a behavior support plan is developed and implemented to assist participants in maintaining their current living environment while ensuring their safety and the safety of others. Consultative Assessment Service is necessary to improve the participant's independence and inclusion in their community. Consultative Assessment Service activities include assessment and habilitation plan development and implementation, and are provided at the direction of a Licensed Independent Mental Health Practitioner (LIMHP), Licensed Psychologist, or Advanced Practice Registered Nurse (APRN).

This service is completed in collaboration with the service planning team and includes a functional behavior assessment including risk levels, the development of a behavior support plan, development of other habilitative plans, training and technical assistance to carry out the plan and treatment integrity support to the participant and the provider in the ongoing implementation of the plan.

A functional behavioral assessment including level of risk is necessary in order to address problematic behaviors in functioning that are attributed to developmental, cognitive and or communication impairments. Observations where the participant lives, and/or takes part in day services or other activities are conducted at any time of the day or night in person or by Telehealth, depending upon when and where the specific problematic behaviors are shown. The current interventions are documented, and efficacy assessed. Best practices in intervention strategies, medical and psychological conditions, and/or environmental impact to service delivery are provided to the participant's team. Behavioral interventions are developed, piloted, evaluated, and revised, as necessary. The purpose is to provide support to the participant, using positive behavior support and non-physical crisis intervention that can keep the participant safe. This service is not duplicative of the Crisis Intervention Support.

Consultative Assessment Service is self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

• The amount of prior authorized services is based on the participant's need as documented in the service plan and is within the participant's approved annual budget.
• Consultative Assessment Service is reimbursed at an hourly unit for up to 5 hours per month.
• Transportation and lodging is included in the reimbursement rate.
• Consultative Assessment Services shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan or HCBS Waiver services. This service may not be provided concurrently with Crisis Intervention Support.
• The provision of Consultative Assessment Services is at the direction of a Licensed Independent Mental Health Practitioner, licensed psychologist, or Advanced Practice Registered Nurse.
• Behavior support plan data with analysis must be documented and accessible in the web-based case management system or submitted to the service coordinator and Division at the frequency approved in the service plan.
• Consultants providing this service must attend either via telecommunication (phone or Telehealth) or in person a minimum of two service plan meetings per ISP year. More frequent attendance may be necessary based on frequency of High General Event Record (GER) reporting.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	
Individual	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultative Assessment Service

Provider Category:
Agency
Provider Type:

Provider Qualifications
License *(specify):*
Licensed in good standing with the Division of Public Health and functioning within their scope of practice, i.e. LIMHP, licensed clinical psychologist or APRN.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120
Certificate *(specify):*
Staff or agencies that provide a service for which a license, certification, or registration, or other credential is required, must hold the license, certification, registration, or credential in accordance with applicable state laws and regulations.
Other Standard *(specify):*
The Medicaid enrolled provider specializing in Developmental Disabilities must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.
A provider delivering direct services and supports must:
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian of the waiver participant; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultative Assessment Service

Provider Category:
Individual
Provider Type:

Provider Qualifications
License *(specify):*
Licensed in good standing with the Division of Public Health and functioning within their scope of practice, i.e. LIMHP, licensed clinical psychologist or APRN.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120
Certificate *(specify):*
Staff or agencies that provide a service for which a license, certification, or registration, or other credential is required, must hold the license, certification, registration, or credential in accordance with applicable state laws and regulations.
Other Standard *(specify):*
The Medicaid enrolled provider specializing in Developmental Disabilities must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.
A provider delivering direct services and supports must:
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian of the waiver participant; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Intervention Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Crisis Intervention Support is an immediate, intensive, and short-term habilitative service that may be added to a participant's plan when a participant's tier level may not sufficiently address temporary increased or severe occurrences of behaviors. The provision of Crisis Intervention Support will be under the direction of a Licensed Independent Mental Health Practitioner (LIMHP), Licensed Psychologist or Advanced Practice Registered Nurse.

This service is completed in collaboration with the service planning team and includes the development of a behavior support plan if Consultative Assessment Service has not occurred previously, development of other habilitative strategies, training and technical assistance to carry out the plan and treatment integrity support to the participant and the provider in the ongoing implementation of the service plan. Crisis Intervention Support is carried out in accordance with functional behavioral assessments and as applicable, in collaboration with of the Consultative Assessment Service provider. Direct support staff with Bachelor degree who may not have clinical experience can implement positive behavior supports, behavioral interventions, and habilitative strategies. This service may be delivered in the participant's home or in the community.

Crisis Intervention Support is not self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

• The amount of authorized services is based on the participant's need as documented in the service plan, and is not limited by the amount approved for the participant's annual budget.
• Crisis Intervention Support must be implemented within 48 hours of request.
• Crisis Intervention Support is reimbursed at an hourly unit for up to 200 hours in a 60 day period.
• Crisis Intervention Support cannot exceed 5 occurrences, defined as a 60-day period, per twelve months.
• Crisis Intervention Support shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan or HCBS Waiver services. This service may not be provided concurrently with Consultative Assessment.
• Behavior support plan data with analysis must be submitted to the Division of Developmental Disabilities at the frequency approved in the service plan.
• The amount of service will be approved by the Clinical Review Team and shall be based on verified need, evidence of the diagnosis or condition requiring this service. The amount of service is subject to approval by the Division based on available waiver funding.
• Transportation and lodging is included in the reimbursement rate.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention Support

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

Staff or agencies that provide a service for which a license, certification, or registration, or other credential is required, must hold the license, certification, registration, or credential in accordance with applicable state laws and regulations.

Certificate *(specify):*

Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation; and
  - Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a legally responsible individual or guardian; and
- Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:

Direct support staff background check compliance is verified through the annual or bi-annual survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modification Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

An Environmental Modification Assessment is a functional evaluation with the participant to ensure the health, welfare and safety of the participant or that enable the participant to integrate more fully into the community, and function in the participant's private home (not provider operated or controlled), or in the participant's family's home, if living with his/her family.

The on-site assessment of the environmental concern includes an evaluation of functional necessity, the determination of the provision of appropriate assistive technology, home, or vehicle modification for the participant, and the need for the modification to ensure cost effectiveness.

Environmental Modification Assessment is self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Participant's annual budget cap for Environmental Modification Assessments is $1,000. A critical health or safety service request that exceeds the annual cap is subject to approval by the Division based on available waiver funding.
- The amount of prior authorized services is based on the participant's need as documented in the participant's service plan, and within the participant's approved annual budget.
- Billing unit is per assessment.
- This service shall not overlap with, supplant, or duplicate other services provided through the Medicaid State plan services.
- Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

Service Delivery Method *(check each that applies):*

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Independent Individual - Non-habilitative services
Agency	Independent Agency - Non-habilitative services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modification Assessment

Provider Category:
Individual
Provider Type:
Independent Individual - Non-habilitative services
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
No certification is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States; and
• Not be a legally responsible individual or guardian: and
• Not be an employee of DHHS.

A provider of this service must:
• Ensure that all items and assistive equipment recommended or provided meet the applicable standards of manufacture, design, and installation.
• Obtain, at a minimum, three bids/cost proposals to ensure cost effectiveness.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modification Assessment

Provider Category:
Agency
Provider Type:
Independent Agency - Non-habilitative services
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
No certification is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

A provider of this service must:
• Ensure that all items and assistive equipment recommended or provided meet the applicable standards of manufacture, design, and installation.
• Obtain, at a minimum, three bids/cost proposals to ensure cost effectiveness.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Habilitative Community Inclusion

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Habilitative Community Inclusion services offer habilitative training and staff supports for the acquisition, retention, or improvement in self-help, and behavioral, socialization, and adaptive skills which take place in the community in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Habilitative Community Inclusion services are furnished in any of a variety of settings in the community.

Habilitative activities are designed to foster greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision. Participants may not perform work activities, either paid or unpaid, while receiving this service.

Habilitative Community Inclusion services provide an opportunity for the participant to practice skills taught in therapies, counseling sessions, or other settings and to plan and participate in scheduled community activities.

Habilitative Community Inclusion services must be furnished consistent with the participant's service plan and include options and opportunities for community integration, relationship-building, and an increased presence in one's community. Habilitative Community Inclusion services include assisting with the common use of the community's transportation system. Habilitative Community Inclusion services may include facilitation of inclusion of the participant within a community group or volunteer organization; opportunities for the participant to join formal/informal associations and community groups; opportunities for inclusion in a broad range of community settings including opportunities to pursue social and cultural interests, and choice making. Habilitative Community Inclusion services include assistance with activities of daily living (ADL), health maintenance, and supervision. Sixty percent of services must occur in community integrated activities.

Habilitative Community Inclusion services may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• This service may be authorized in combination with any, or all, of the following services in the same service plan, but not during the same time period: Adult Day Services, Supported Employment (Individual, Enclave, and Follow-Along), Prevocational, and/or Habilitative Workshop. The total combined hours for these services may not exceed a weekly amount of 35 hours.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Habilitative Community Inclusion is reimbursed at an hourly unit.
• The rate tier for Habilitative Community Inclusion is determined based upon needs identified in the Objective Assessment Process.
• Transportation to and from the participant's private residence, or other provider setting, to settings in the community for Habilitative Community Inclusion services is included in the reimbursed rate.
• Habilitative Community Inclusion shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan or HCBS Waiver services.
• Habilitative Community Inclusion Services may be provided by a relative but not a legally responsible individual or guardian.
• An individual service provider or agency provider staff shall not provide Habilitative Community Inclusion services to adults and children at the same time. Participants who are age 18 to 19 may receive Habilitative Community Inclusion services with adults served under this waiver.
• A Habilitative Community Inclusion service provider or provider staff must be 19 years of age or older.

Service Delivery Method *(check each that applies):*

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Individual - Habilitative Services
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Habilitative Community Inclusion

Provider Category:
Individual
Provider Type:
Independent Individual - Habilitative Services
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
No certification is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Have necessary education and experience, and provide evidence upon request:
o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR

o Have any combination of education and experience identified above equaling four years or more;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Habilitative Community Inclusion

Provider Category:
Agency

Provider Type:
DD Agency

Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian;
• Not be an employee of DHHS; and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Habilitative Workshop

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Habilitative Workshop services are habilitative services that offer a provision of regularly scheduled activities in a provider owned or controlled non-residential setting. Habilitative Workshop services are regularly scheduled activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. This service is provided to participants that do not have a clear plan for employment and are therefore not currently seeking to join the general work force. Services are not job-task oriented, but aimed at generalized results.

Habilitative Workshop services will focus on enabling the participant to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies listed in the service plan. In addition, the services and supports may reinforce but not replace skills taught in therapy, counseling sessions, or other settings. This service also includes the provision of personal care, health maintenance and supervision.

Habilitative Workshop is not self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• This service may be authorized in combination with any, or all, of the following services in the same service plan, but not during the same time period: Adult Day Services, Supported Employment (Individual, Enclave, and Follow-Along), Habilitative Community Inclusion, and/or Prevocational. The total combined hours for these services may not exceed a weekly amount of 35 hours.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Habilitative Workshop is reimbursed at an hourly unit.
• The rate tier for this service is determined based upon needs identified in the Objective Assessment Process.
• Transportation to and from the participant's private residence, or other provider setting, to a Habilitative Workshop setting is not included in the reimbursement rate.
• Transportation to and from the Habilitative Workshop setting to integrated community activities during the Habilitative Workshop service hours is included in the rate.
• Habilitative Workshop shall not overlap with, supplant, or duplicate other services provided through Medicaid State Plan or HCBS Waiver services, or Vocational Rehabilitation programs.
• Effective March 1, 2017, documentation for any supported employment service must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Habilitative Workshop

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  o Cardiopulmonary resuscitation; and
  o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian;
• Not be an employee of DHHS; and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home Modifications are those physical adaptations to the private residence of the participant or the participant's family that are necessary to ensure the health, welfare, and safety of the participant, and/or are necessary to enable the participant to function with greater independence in their own participant-directed private home (not provider operated or controlled) or in the family's home, if living with his/her family.

Home Modifications are provided within the current foundation of the residence. Such modifications include the installation of ramps, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Approvable adaptations do not include adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. The participant's home must not present a health and safety risk to the participant other than that corrected by the approved home adaptations. Home Modifications will not be approved to adapt living arrangements for a residence that is operated or controlled by a provider of waiver services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Home Modification has a budget cap of $10,000 per five year period.
• A critical health or safety service request that exceeds the cap subject to approval by the Division based on available waiver funding.
• The Division may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. The Division may use a third party to assess the proposed modification and need for the adaptation to ensure cost effectiveness and quality of product. This assessment will be funded by the Environmental Modification Assessment service, and will be reimbursed separately. The cost of the Environmental Modification Assessment is not included in the $10,000 budget cap for Home Modification.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Home Modifications shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan services.
• Proof of renter's insurance or homeowner's insurance may be requested.
• Evidence of application to secure government-subsidized housing through U.S. Department of Housing and Urban Development or other Economic Assistance programs may be requested.
• Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Individual - Non-Habilitative
Agency	Independent Agency, Department of Education, Companies for Specialized Equipment, supplies, home repair

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual
Provider Type:
Independent Individual - Non-Habilitative
Provider Qualifications
License *(specify):*
All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.
Certificate *(specify):*
All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.
A provider of this service must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons shall make or oversee all modifications.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Agency

Provider Type:
Independent Agency, Department of Education, Companies for Specialized Equipment, supplies, home repair

Provider Qualifications

License *(specify):*
All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.

Certificate *(specify):*
All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons shall make or oversee all modifications.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Integrated Community Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Integrated Community Employment (ICE) service is intermittent formalized training and staff supports - needed by a participant to acquire and maintain a job/position in the general workforce at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment in an integrated setting in the general workforce that meets personal and career goals, as documented in the service plan. ICE services are person-centered and team supported to address the participant's particular needs for ongoing or intermittent habilitation (teaching and supporting) throughout stabilization services and extended integrated community employment services and supports. Intermittent services imply that staff support is provided when the services and supports are needed. ICE, as an intermittent service, can only be billed in half, quarter hours, or full hour increments. An hour of service equates to one clock hour.

ICE services include habilitation (teaching and supporting) services, with activities and strategies that are outcome based and focused to sustain paid work by participants and are designed to obtain, maintain or advance employment. Intensive direct habilitation (teaching and supporting) will be designed to provide the participant with face to face instruction necessary to learn explicit work-related responsibilities and skills, as well as appropriate work behavior.

ICE services enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need

supports, to perform in a regular work setting. Support may involve assisting the participant in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

ICE services are primarily provided away from the home, in a non-residential setting, during typical working hours. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in the service plan. Discreet habilitation (teaching and supporting) during typical working hours is allowed in preparation for leaving the place where the participant lives. Intermittent face to face individualized habilitation (teaching and supporting) is provided to assist the participant in maintaining employment. Habilitation (teaching and supporting) goals and strategies must be identified in the service plan and specify in a measurable manner, the services to be provided to meet the preferences and needs of the participant.

ICE services may include a customized home-based business. Habilitation (teaching and supporting) services may be delivered in a customized home based businesses and are allowed in participant directed companion homes. ICE services do not include employment in group settings such as Workstation services, enclaves, classroom settings, or provider-owned and controlled fixed site Day Habilitation settings.

Stabilization is ongoing habilitation (teaching and supporting) services and strategies needed to support and maintain a participant in an integrated competitive employment site or customized home-based employment. Stabilization habilitation (teaching and supporting) services, supports, and strategies are provided when the staff intervention time required at the job site is 20% - 50% of the participant's total work hours. Staff intervention includes regular contacts with the participant or on behalf of the participant to determine needs, as well as to offer encouragement and advice. Staff is intermittently available as needed to the participant during employment hours. Goals and strategies needed for the participant to maintain employment must be identified in the individual plan.

Extended ICE services are provided to participants who need ongoing intermittent support to maintain employment and when the staff intervention time required at the job site is less than 20% of the participant's total work hours. The provision of extended ICE is limited to the work site, including home-based business sites. Staff supports must include at a minimum, twice monthly monitoring at the work site. Extended ICE services must identify the services and supports needed to meet the needs of the participant in the service plan.

Prior to learning to access transportation independently, transportation between the participant's place of residence and the employment site is a component of ICE services and the cost of transportation is included in the rate paid to providers.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
Payments that are passed through to users of supported employment programs; or
Payments for training that is not directly related to a participant's integrated community employment services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Integrated Community Employment services offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Integrated Community Employment services and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

The amount of authorized services is the participant's approved annual budget and is provided based on the participant's preferences to the extent possible, and as documented in the service plan. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

ICE stabilization services require at least 40 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue reimbursement at the ICE rate as long as the minimum total number of hours worked for the last three months (including the current month) is more than 120 hours of work (or an average of 40 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 40 hours of employment per month.

Extended ICE services are time limited. Extended integrated community employment services require at least 80 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue payment for the extended ICE services as long as the minimum total number of hours worked for the last three months (including the current month) is more than 240 hours of work (or an average of 80 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 80 hours of employment per month. The provider may claim extended integrated community employment services for up to 24 months in order for the participant to meet their personal and career goals.

Income from customized home-based businesses may not be commensurate with minimum wage requirements with other employment. No more than two individuals may participate in a home-based business at the same participant-directed companion home.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Integrated Community Employment

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify)*:
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and

o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Medical Risk Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02023 shared living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Medical risk services are provided to participants with complex medical needs that require continuing care and treatment but are not assessed to need continuous nursing facility level of care. Complex medical needs may result from the diagnoses of some types of diabetes or seizures or may result from use of g-tubes, g-buttons, j-tubes, tracheotomies, ventilators, or a combination of the above. Treatment or interventions to meet complex medical needs require ongoing clinical assessment, professional judgment, and treatment based on ongoing assessment and cannot be delegated to unlicensed direct support professionals.

Medical risk services are also available to participants who have a degenerative/regressive condition diagnosed by the participant's medical practitioner and that make further growth or development unlikely. The degenerative/regressive condition requires continuing care and treatment, and significantly impedes independent completion of activities of daily living, and impedes self-directing others to perform activities of daily living. Degenerative or regressive conditions that affect all areas of daily living activities may include cerebral palsy, muscular dystrophy, multiple sclerosis, post-polio syndrome, dementia, Parkinson's disease, Huntington's disease, Alzheimer's, or other neurological impairments.

The need for medical risk services will be determined by designated staff at Division of Developmental Disabilities (DDD) central office. A referral is completed by the participant's service planning team to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of DDD central office. When the team, which may include the participant's physician, believes that the participant's needs require medical risk services, the participant may be referred to DD central office for a formal health assessment.

Medical risk services are provided 24/7 and are considered to be continuous services. This service is an all-inclusive service that includes residential and day habilitation (teaching and supporting), health maintenance activities, routine complex medical treatments, ongoing health and safety supervision, and ongoing clinical supports. The provision of medical risk services will be under the direction of a registered nurse. Physical nutritional management plans must be implemented as applicable Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

The residential habilitation (teaching and supporting) under this service can be delivered in a variety of home settings. The residential habilitation component is formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Medical risk services are all-inclusive, meaning that a participant cannot receive these services in combination with another DD waiver service. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to his/her needs. Residential habilitation (teaching and supporting) also includes personal care and protective oversight when applicable as well as supervision.

The day habilitation (teaching and supporting) service component, is provided away from the home, unless prescribed to be medically necessary by the participant's physician and approved by DDD central office, and is provided during typical working hours to increase the participant's independence, integration, inclusion, personal accomplishment, and employment objectives, as applicable. Day habilitation services that are provided as part of this all-inclusive service are provided in non-residential settings in the community. A participant cannot be authorized for another day habilitation service and medical risk services at the same time. The habilitation (teaching and supporting) services are formalized training and supports, which focus on enabling the participant to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies in the ISP. The habilitative training and supports may include workplace training, increasing socialization and recreational skills and abilities in the community, and skills to assist in access to and integration in their community. The day habilitation (teaching and supporting) component also includes personal care and protective oversight (when applicable) as well as supervision.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are not an exclusive component of medical risk services and are provided when identified as a need and documented in the service plan.

Assistance with personal needs may include toileting, transfer and ambulation, skin care, bathing, dressing, grooming, meal preparation, eating, extension of therapies and exercise, and routine care of adaptive equipment primarily involving cleaning as needed.

Treatments or interventions to meet complex medical needs or address degenerative conditions are outlined in a nursing plan and included in the participant's service plan. Health and safety

factors including the type and amount of supervision, environmental conditions, weather conditions, architectural conditions, special diets, and safe evacuation plans are included in the service plan as applicable to the participant.

Medical risk providers must have a sufficient number of Registered Nurses on staff or under contract to develop nursing plans, provide complex medical treatments, train unlicensed direct support professionals, and oversee delegation of health maintenance activities to the extent permitted under applicable state laws.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Medical Risk Services offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Medical Risk Services and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

Medical risk services are not participant directed. The amount of authorized services for medical risk services may not be determined using the objective assessment process.

Complex medical treatments require ongoing assessment, professional judgment, and treatment based on ongoing assessment and can only be delegated to unlicensed direct support professionals to the extent permitted under Neb. Rev. Statute § 71-1, 132.30.

Payments for medical risk services are not made for room and board, the cost of setting maintenance, upkeep, and improvement.

Payment for medical risk services does not include DDD payments made, directly or indirectly, to members of the participant's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The provision of medical risk services cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, or Medicaid State Plan services. Medical risk services will not duplicate other services provided through this waiver. Medical risk services are all-inclusive, meaning that a participant cannot receive these services in combination with another DD waiver service. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Risk Services

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify)*:
Registered Nurses that provide a complex medical treatment or intervention or that delegate non-complex treatments to direct support staff must be licensed in accordance with applicable state laws and regulations. Neb. Rev. § 38-2201
Certificate *(specify)*:
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify)*:
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  o Cardiopulmonary resuscitation; and
  o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
PERS is an electronic device which enables participants to secure help in an emergency. The participant may also wear a portable PERS button to allow for mobility. The system is connected to the participant's telephone and programmed to signal a response center once a PERS button is activated.

The provision of PERS includes:
1. Instruction to the participant about how to use the PERS device;
2. Obtaining the participant's or authorized representative's signature verifying receipt of the PERS unit;
3. Ensuring that response to device signals (where appropriate to the device) will be provided 24 hours per day, 7 days per week;
4. Furnishing a replacement PERS unit when needed to the participant within 24 hours of notification of malfunction of the original unit while it is being repaired;
5. Updating a list of responder and contact names at a minimum semi-annually to ensure accurate and correct information;
6. Ensuring monthly testing of the PERS unit; and
7. Furnishing ongoing assistance when needed to evaluate and adjust the PERS device or to instruct the participant in the use of PERS devices, as well as to provide for system performance checks.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• PERS is limited to participants who live alone or who are alone for significant parts of the day and have no regular unpaid caregiver or provider for extended periods of time.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• PERS is reimbursed as a monthly rental fee or as a one-time installation fee.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Agency
Provider Type:
Independent Agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
No certificate is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation.

A provider of this service must:
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

A provider of this service must:
• Complete all provider enrollment requirements;
• Ensure response is provided 24 hours per day, 7 days per week;
• Furnish replacement PERS unit within 24 hours of malfunction of original unit;
• Ensure monthly testing of PERS unit; and
• Update responder contacts semi-annually.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Retirement Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Retirement services are available to participants who are of the typical retirement age. Participants of this service have chosen to end employment or participation in day habilitation services or are no longer able to be employed or participate in day habilitation services due to physical disabilities or stamina. Retirement services are structured services consisting of day activities and residential support. Retirement services are provided in a home setting or community day activity setting and may be provided as a day service or a residential service. Retirement services may be self-directed or provider controlled. The outcome of retirement services is to treat each participant with dignity and respect, and to the maximum extent possible maintain skills and abilities, and to keep the participant engaged in their environment and community through optimal care and support to facilitate aging within the participant's home and community.

Retirement services and supports are designed to actively stimulate, encourage and enable active participation; develop, maintain, and increase awareness of time, place, weather, persons, and things in the environment; introduce new leisure pursuits, establish new relationships; improve or maintain flexibility, mobility, and strength; develop and maintain the senses; and to maintain and build on previously learned skills.

Active supports must be furnished in a way which fosters the independence of each participant. Strategies for the delivery of active supports must be person centered and person directed to the maximum extent possible and must be identified in the service plan.

Retirement services and supports may include personal care, protective oversight, and supervision as applicable to the participant when provider staff is present. Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Meals provided as part of retirement services and supports do not constitute a "full nutritional regimen" (3 meals per day).

Retirement services may be provided as a continuous or intermittent service. Continuous day service activities are provided for seven or more hours per day and delivered in a non-institutional, community setting that may include people without disabilities. Retirement day settings cannot be set up or operated by a DD provider in communities where an existing community senior center or facilities geared for people who are elderly, such as an adult day care center are available. DD provider-operated retirement day settings must be made available to people without disabilities.

Continuous retirement residential supports are provided for seven or more hours per day and may be provided in supported living companion homes or provider operated residences. A supported living companion home has no more than two other individuals with developmental disabilities and is under the control and direction of the individual(s). The home or residence must be in an integrated community setting.

When retirement services are delivered in a provider operated residence, there must be staff on-site or within proximity to allow immediate on-site availability at all times to the participant, including during the participant's sleep time. Staff must be available to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, to provide supervision, safety, and security, and to provide activities to keep the participant engaged in their environment.

The personal living space and belongings of others must not be utilized by others receiving retirement services. When retirement services are delivered in residences, only shared living spaces such as the living room, kitchen, bathroom, and recreational areas may be utilized, and when retirement services are delivered to two or more participants, different residences must be utilized on a rotating basis.

Transportation into the community to shop, attend recreational and civic events, go to the senior center, adult day care center, or other community activities is a component of retirement services and is included in the rate to providers. It shall not replace transportation that is already reimbursable under the Medicaid non-emergency medical transportation program. The service planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by the provider is not intended to replace generic transportation or to be used merely for convenience.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Retirement Services offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Retirement Services and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

Payments for retirement services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for retirement services does not include payments made, directly or indirectly, to members of the participant's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant.

The amount of authorized services is the participant's approved annual budget and is provided based on the participant's preferences to the extent possible, and as documented in the service plan.

Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Retirement day supports cannot duplicate or replace existing natural supports, senior centers, adult day care centers, or other community activity centers in the communities in which the participant resides.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Retirement Services

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify)*:
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Supported Employment - Enclave

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supported Employment-Enclave are habilitative services and activities provided in regular business and industry settings for groups. Generally, participants work as a team, at a single worksite of a community business or industry, with initial training, supervision, and ongoing support provided by a specially trained on-site supervisor, who is an employee of the DD provider agency.

Supported Employment-Enclave does not include services provided in facility based work settings. Services take place at a work site of a competitive employer where a participant with a disability or a group of participants with disabilities are working and supervised by staff from the DD provider agency. The participants remain on the provider's payroll and authorization to pay a subminimum wage is based on the provider's certificate.

Examples include mobile crews and other business-based workgroups employing small groups of participants with disabilities in integrated employment in the community. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which a participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported Employment-Enclave may include the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the participant to attain or maintain his or her maximum inclusion, and personal accomplishment in the working community. Supported Employment-Enclave may include services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting. Supported Employment-Enclave must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.

Supported Employment-Enclave is not self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• This service may be authorized in combination with any, or all, of the following services in the same service plan, but not during the same time period: Adult Day Services, Supported Employment (Individual and Follow-Along), Habilitative Community Inclusion, Prevocational, and/or Habilitative Workshop. The total combined hours for these services may not exceed a weekly amount of 35 hours.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• This service is billed at an hourly unit.
• Transportation to and from the participant's private residence, or other provider setting, to Supported Employment-Enclave is not included in the reimbursement rate.
• Supported Employment-Enclave shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan, HCBS Waiver services, or Vocational Rehabilitation.
• Effective January 1, 2017, documentation for any supported employment service must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).
• Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
o Payments that are passed through to users of supported employment programs; or
o Payments for training that is not directly related to a participant's supported employment program.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Enclave

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Employment - Follow Along

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported Employment-Follow Along are services and supports that enable a participant who is paid at or above the federal minimum wage to maintain employment in an integrated community employment setting. This service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. Supported Employment-Follow Along may include support through phone calls between provider staff and the participant's employer staff. There is regular contact and follow-up with the employer and participant to reinforce and stabilize job placement. Services must be furnished consistent with the participant's person-centered plan.

Supported Employment-Follow Along must include observation and supervision of the participant, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of the job placement and when needed, the provision of short-term job skill training at the work site to help maintain employment. Supported Employment-Follow Along staff provide facilitation of natural supports at the work site and advocate for the participant, but only with persons at the employment site (e.g., employers, co-workers, customers) and only for purposes directly related to employment.

A participant may receive Supported Employment-Follow Along for working in an integrated community work environment where at least 51% of other employees who work around the participant do not have disabilities.

Supported Employment-Follow Along Services may be self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

• This service may be authorized in combination with any, or all, of the following services in the same service plan, but not during the same time period: Adult Day Services, Habilitative Community Inclusion, Prevocational, and/or Habilitative Workshop. The total combined hours for these services and Supported Employment-Follow Along may not exceed a weekly amount of 35 hours.
• Supported Employment-Follow Along does not include activities taking place in a group, e.g., work crews or enclaves; public relations; community education; in-service meetings; individual staff development; department meetings; or any other activities that are non-participant specific, such as a job coach working the job instead of the participant.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Supported Employment-Follow Along is reimbursed in 15 minute units for up to 100 units annually.
• Transportation to and from the participant's private residence, or other provider setting, to the Supported Employment-Follow Along is not included in the reimbursement rate.
• This service shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan, HCBS Waiver services, or Vocational Rehabilitation.
• Effective March 1, 2017, documentation for any supported employment service must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).
• Supported Employment-Follow Along may be provided by a relative but not a legally responsible individual or guardian.
• A Supported Employment-Follow Along service provider or provider staff must be 19 years of age or older to provide services.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Individual - Habilitative Services
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Follow Along

Provider Category:

Individual

Provider Type:

Independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Have necessary education and experience, and provide evidence upon request:
o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
o Have any combination of education and experience identified above equaling four years or more;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS and
• Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:

Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Follow Along

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:

Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Team Behavioral Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Team behavioral consultation is on-site consultation by highly specialized teams with behavioral and psychological expertise when participants with DD experience psychological, behavioral, or emotional instability which has been resistant to other standard habilitative interventions and strategies that have been attempted by the participant's ISP team. Sometimes in rural areas of the state, community resources, such as psychologists or psychiatrists are not readily available to consult with or participate in meetings, or have very little experience with treating individuals with DD. Team behavioral consultation service may be requested by the ISP team or directed by DDD central office and the need for the service is reflected in the ISP.

Team behavioral consultation (TBC) service includes reviewing referral information, an entrance conference, on-site observations, interviews, and assessments, training to direct support staff, identification of the need for referral(s) to other services if applicable, an exit conference, report of findings and recommendations, and follow-up.

The service begins with submission of a referral to DDD central office to log and forward to the assigned TBC team. The TBC team contacts the participant's service coordinator (SC) to schedule a consultation visit and the SC submits informational packet to the TBC team for review prior to the scheduled visit. The on-site consultation begins with an initial meeting of the service plan team, the participant, legal representative and/or parent, service coordinator, staff from habilitation service components delivered to the participant (day services, residential services, or both day and residential services), other professionals serving the participant in the community, as well as TBC service staff.

The TBC service is provided under the direction of a Licensed Clinical Psychologist, and may include the following members, depending upon the participant's needs: a Certified Master of Social Work, a Registered nurse, a licensed mental health practitioner, or other qualified professionals. This meeting is designed to further explore the negative behavior and plan the schedule for the on-site consultation.

Observations where the participant lives, and/or takes part in day services or other activities are conducted at any time of the day or night, depending upon when and where the specific negative behaviors are exhibited. ISP team members are interviewed, and assessments are completed. The current interventions are noted, and efficacy assessed. Behavioral interventions are developed, piloted, and evaluated, and revised, as necessary. Training is delivered to the ISP team as applicable and requested, such as best practices in intervention strategies, medical and psychological conditions, or environmental impact to service delivery.

Findings and recommendations are written and discussed with the team at the exit conference and a copy is provided to DDD central office. The participant is present for the consultation.

If at any time the TBC team identifies a need for a referral as a result of the review of the participant's case file, observations, interviews, and/or completion of assessments, the TBC will notify the participant's DDD service coordinator to recommend/direct that a referral be made for needs such as, but not limited to a medication review, dental work, medical evaluation, or nutritional evaluation. Such referral recommendations are documented in the TBC report.

Follow-up begins after the TBC staff has left the community site. It includes all revisions to the recommendations package, and phone, e-mail, and on-site contact with the participant's ISP team in the community. Weekly contact with the ISP team is conducted by telephone or e-mail to provide support and additional recommendations, as needed. Behavioral data and Treatment Integrity checklists are reviewed on an on-going basis, with on-site follow-up conducted if problem behaviors continue to be resistant in spite of consistently applied efforts. Continued follow-up is provided after each successive on-site visit. The TBC file is closed when there is agreement to do so by TBC staff and the participant's ISP team.

The recommendations from the TBC service provider for addressing behaviors and intervention strategies must be addressed by the participant's service plan team and changes resulting from the recommendations are documented in the service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Team Behavioral Consultation offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Team Behavioral Consultation and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

Team behavioral consultation is only available to participants receiving services from a certified DD agency provider. TBC will not be available to participants that receive behavioral risk services or retirement services.

TBC services will not be furnished to a participant while s/he is an inpatient of a hospital, nursing facility, or ICF. Room and board is not included as a cost that is reimbursed under this service.

To avoid overlap or duplication of service, team behavioral consultation services are limited to those services not already covered under the Medicaid State Plan or which can be procured from other formal or informal resources such as Rehab act of 1973. Furthermore, TBC services will not duplicate other services provided through this waiver.

A unit of team behavioral consultation is defined as a day.

The authorized amount of team behavioral consultation is not determined using the objective assessment process. The funding amount and duration of the service is set by DDD and is not based on the objective assessment process described in I-2-a.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Team Behavioral Consultation

Provider Category:
Agency
Provider Type:
DD Agency

Provider Qualifications

License *(specify):*
Team behavioral consultation staff that is a psychologist, medical staff, or a mental health practitioner are required to be licensed in accordance with applicable state laws and regulations.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120

Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  o Cardiopulmonary resuscitation; and
  o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Transitional Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Transitional Services are services and household set-up expenses not otherwise provided through this waiver or through the Medicaid State Plan that enables a participant to have opportunities for full membership in home and community based services.

Transitional Services are non-recurring basic household set-up expenses needed for participants transitioning from an institution to a private residence that remove the identified barriers or risks for the success of the transition. Transitional Services may include essential furniture, furnishings, household supplies, security deposits, basic utility (i.e., water, gas, and electricity) fees or deposits, or moving expenses. Funds may not be used to pay a rental deposit or rent. Transitional Services may be approved when the participant does not have the funds to purchase the item or service or the item or service is not available through another source, including relatives, friends, or any other source. Transitional Services will not be approved for a residence that is owned or leased by a provider of waiver services.

Transitional Services may be self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Transitional Services have a participant budget cap of $1,500. A critical health or safety service request that exceeds the limit is subject to approval by the Division of Developmental Disabilities based on available waiver funding.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Transitional Services are authorized for direct reimbursement to the vendor.
• Medicaid funds may not be used to pay rent.
• An application must be submitted to Department of Health and Human Services Division of Children & Family Services Economic Support Unit for assistance prior to utilization of this service.
• Transitional Services cannot be used for personal care items (toiletries or things used for daily hygiene), food, or clothing, or items and services which are not essential to supporting the move or ensuring a successful transition.
• Transitional Services shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan services, Money Follows the Person, or Nebraska DHHS Economic Support programs.

• Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency/Company – Non-Habilitative
Individual	Independent Individual - Non-Habilitative

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:
Agency
Provider Type:
Independent Agency/Company – Non-Habilitative
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
No certification is required.
Other Standard *(specify)*:
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:
Individual
Provider Type:
Independent Individual - Non-Habilitative
Provider Qualifications
License *(specify)*:
A license is not required.
Certificate *(specify)*:
No certificate is required.
Other Standard *(specify)*:
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Transportation is a service designed to foster greater independence and personal choice. Transportation services enable participants to gain access to waiver services, community activities, and resources as specified by the participant's service plan. Transportation services are not intended to replace formal or informal transportation options, like the use of natural supports.

Transportation Services may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• This service does not include transportation to medical appointments that is available under the Medicaid State plan or other federal and state transportation programs.
• Transportation is provided for a waiver participant to get to and from a location only.
• Participant's annual budget cap for Transportation service is $5,000. A critical health or safety service request that exceeds the annual cap is subject to approval by the Division of Developmental Disabilities based on available waiver funding.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• Transportation is reimbursed per mile or cost of a bus pass.
• Transportation shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan or HCBS Waiver services.
• Transportation services may be provided by a relative but not a legally responsible individual or guardian.
• Agency provider mileage rate shall not exceed the rate of reimbursement pursuant to Neb. Rev. Stat. §81-1176 multiplied by three.
• Individual provider mileage rate shall be paid at the mileage rate of reimbursement pursuant to Neb. Rev. Stat. §81-1176.
• The public transportation rate shall not exceed purchase price by the general public.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency - Public Service Commission Exempt Transportation Provider
Agency	Agency - Certified Commercial Carrier/Common Carrier
Individual	Individual - Individual Transportation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Agency - Public Service Commission Exempt Transportation Provider
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certificate to operate as a public transit authority issued by the Nebraska Department of Roads.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Ensure drivers possess a current and valid driver's license;
• Maintain the minimum vehicle insurance coverage as required by state law;
• Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years;
• Meet and adhere to all applicable employment standards established by the hiring agency; and
• Be age 19 or older and authorized to work in the United States.

The provider must have internet access for adherence to applicable record-keeping and billing requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency

Provider Type:
Agency - Certified Commercial Carrier/Common Carrier

Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
Certificate of Authority issued by the Nebraska Public Service Commission.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must:
• Complete all provider enrollment requirements;
• Ensure drivers possess a current and valid driver's license;
• Maintain the minimum vehicle insurance coverage as required by state law;
• Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years
• Meet and adhere to all applicable employment standards established by the hiring agency; and
• Be age 19 or older and authorized to work in the United States.

The provider must have internet access for adherence to applicable record-keeping and billing requirements

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Individual - Individual Transportation Provider

Provider Qualifications

License *(specify):*
Provider must have a valid driver's license.

Certificate *(specify):*
No certificate is required.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code.

A provider of this service must:
• Complete all provider enrollment requirements;
• Use their own personally registered vehicle to transport;
• Maintain the minimum vehicle insurance coverage as required by state law;
• Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years;
• Be age 19 or older and authorized to work in the United States; and
• Not be an employee of DHHS.

The provider must have internet access for adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.

Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Vehicle Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

The following are specifically excluded:
1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant.
2. Purchase or lease of a vehicle.
3. Purchase of existing adaptations or adaptations in process.
4. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
5. Vehicle Modifications will not be approved to adapt automobiles or vans that are owned or leased by providers of waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Vehicle Modification services has a budget cap of $10,000 per five year period.
• A critical health or safety service request that exceeds the cap is subject to available waiver funding and approval by the Division of Developmental Disabilities.
• The Division may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. The Division may use a third party to assess the proposed modification and need for the modification to ensure cost effectiveness and quality of product. This assessment will be funded by the Environmental Modification Assessment service, and will be reimbursed separately. The cost of the Environmental Modification Assessment is not included in the $10,000 budget cap for Vehicle Modification.
• The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.
• The following are specifically excluded:
  1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant.
  2. Purchase or lease of a vehicle.
  3. Purchase of existing adaptations or adaptations in process.
  4. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
  5. Vehicle Modifications will not be approved to adapt automobiles or vans that are owned or leased by providers of waiver services.
• Proof of vehicle insurance may be requested.
• Vehicle Modifications shall not overlap with, supplant, or duplicate other services provided through Medicaid State plan or HCBS Waiver services.
• Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.
• If the vehicle is leased, the modification is transferrable to the next vehicle.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency/Business; Department of Education; Vocational Rehabilition Assistive Techology Partnership; Companies for Specialized Equipment; Businessess for Vehicle adaptions.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:
Agency
Provider Type:
Independent Agency/Business; Department of Education; Vocational Rehabilition Assistive Techology Partnership; Companies for Specialized Equipment; Businessess for Vehicle adaptions.
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
No certification is required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Codes.

A provider of this service must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons shall make or oversee all modifications.

A provider of this service must:
• Complete all provider enrollment requirements;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements when the service is delivered in a provider setting.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vocational Planning Habilitation Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Vocational Planning habilitation (teaching and supporting) service is a prevocational service with focus on enabling the participant to attain work experience through career planning, job searching, and paid and unpaid work experience with the goal or outcome of Vocational Planning being integrated community employment. Services are furnished as specified in the service plan and are delivered intermittently. Intermittent services imply that staff support is provided when the services and supports are needed. Vocational Planning services can only be billed in half, quarter, or full hour increments. An hour of service equates to one clock hour.

Vocational Planning habilitation (teaching and supporting) services are formalized training and staff supports which take place during typical working hours, in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as within a business or a community setting not owned or controlled by a DD provider, where individuals without disabilities work or meet together. Discreet habilitation (teaching and supporting) during typical working hours is allowed in preparation for leaving the place where the participant lives. Direct training or teaching and supports will be designed to provide the participant with face to face instruction necessary to learn work-related responsibilities, work skills, and appropriate work behavior.

Vocational Planning habilitation (teaching and supporting) services focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the participant to attain or maintain his or her maximum inclusion and personal accomplishment in the working community. Habilitation (teaching and supporting) may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives. Vocational Planning habilitation (teaching and supporting) services also includes the provision of personal care and protective oversight and supervision when applicable to the participant. The teaching, activities, services, supports, and strategies are documented in the service plan and delivered based on the service plan.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Vocational Planning habilitation (teaching and supporting) services may include career planning that is person-centered and team supported to address the participant's particular needs to prepare for, obtain, maintain or advance employment. Habilitation (teaching and supporting) services with focus on career planning includes development of self-awareness and assessment of skills, abilities, and needs for self-identifying career goals and direction, including resume or business plan development for customized home businesses. Assessment of skills, abilities, and needs is a person-centered team responsibility that engages all team members to support an participant in identifying a career direction and developing a plan for achieving integrated community employment at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The documented outcome is the stated career goals and career direction and strategies for the acquisition of skills and abilities needed for work experience in preparation for integrated community employment. Establishment of career goals may not take place at the same time as other Vocational Planning activities.

Habilitation (teaching and supporting) services with focus on career planning and strategies for implementing career goals may involve assisting the participant in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

Vocational Planning habilitation (teaching and supporting) services may include job searching designed to assist the participant, or on behalf of the participant, to locate a job or development of a work experience on behalf of the participant. Job searching may take place in the participant's residence, in integrated community settings, or in provider staff office areas. Job searching may not take place in a fixed-site facility in the areas where other participants are receiving continuous day habilitation (teaching and supporting) services. Job searching with the participant will be provided on a one to one basis to achieve the outcome of this service.

Vocational Planning habilitation (teaching and supporting) services may include work experiences that are paid or unpaid, such as volunteering, apprenticing, interning, job shadowing, etc. A work experience takes place during typical working hours, in a non-residential setting, separate from the participant's private residence or other residential living arrangement, with the focus on attaining the outcome of integrated community employment. Habilitation (teaching and supporting) provided during a work experience may include teaching such concepts as self-direction, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

Prior to learning to access transportation independently, transportation may be provided between the participant's place of residence and the vocational planning habilitation (teaching and supporting) services or between habilitation (teaching and supporting) service sites (in cases where the participant receives habilitation services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services. The cost of transportation between vocational planning habilitation and day habilitation, workstation habilitation and integrated community employment should be billed under those waiver services and not this service.

Vocational Planning habilitation (teaching and supporting) services may take place in conjunction with Integrated Community Employment services, Workstation habilitation (teaching and supporting) services, Day Habilitation service, or other day activities but may not be billed at the same time during a given day.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Vocational Planning Habilitation services offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Vocational Planning Habilitation services and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

The amount of authorized services is the participant's approved annual budget and is provided based on the participant's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Some components of Vocational Planning habilitation (teaching and supporting) services are time-limited. Establishment of career goals through career planning may not exceed three

months. If the outcome of career planning is not reached within three months, a team meeting must be held to change the service plan. Unpaid work experiences must lead to paid employment and are therefore time-limited. Work experiences for which the general population is paid to perform may not last beyond six months. Volunteering to provide services and supports in an integrated community setting for which the general population does not get paid to perform are not considered to be a work experience and are not time-limited. No more than three participants may participate in the same paid or unpaid work experience at the same time.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vocational Planning Habilitation Service

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify)*:
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a legally responsible individual or guardian; and
• Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Workstation Habilitation Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Workstation habilitation (teaching and supporting) services are formalized training and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, community living, and employment. Workstation habilitation (teaching and supporting) services take place during typical working hours, in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as within a business or a community setting where individuals without disabilities work or meet together. Discreet training activities and supports during typical working hours is allowed in preparation for leaving the place where the participant lives.

Workstation habilitation (teaching and supporting) services focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the participant to attain or maintain his or her maximum inclusion, inclusion, and personal accomplishment in the working community. Training activities may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the participant, as well as supervision at the workstation setting. In addition, the intensity of supervision will also be outlined in the service plan. Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. The habilitative services, supports, and strategies are documented in the service plan and delivered based on the service plan.

Workstation habilitation (teaching and supporting) services are delivered continuously and provide paid work experiences in preparation for competitive employment. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in a participant's service plan. Staff support is continuous, that is, staff are present at all times the participant is present. Daily rates are available for workstation habilitation services when the participant receives this service for four or more consecutive hours. Hourly rates are also available for times when the participant might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75). When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973.

Transportation may be provided between the participant's place of residence and the workstation habilitation (teaching and supporting) services or between habilitation (teaching and supporting) service sites (in cases where the participant receives habilitation services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services. The cost of transportation between workstation habilitation and other habilitation service sites should be billed under those waiver services and not this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is only available under this waiver until September 30, 2017 and at such time this service will end and cannot be offered. Workstation Habilitation services offered in this waiver are available to current waiver participants only, until the waiver participant transitions to new services offered under this waiver. New waiver participants cannot choose Workstation Habilitation services and current waiver participants cannot choose this service at their next annual, semi-annual or special ISP meeting.

The amount of authorized services is the participant's approved annual budget and is provided based on the participant's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DD Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Workstation Habilitation Services

Provider Category:
Agency
Provider Type:
DD Agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification by the Division of Public Health in accordance with applicable state laws and regulations. Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act.
Other Standard *(specify):*
The DD provider agency must be a Medicaid provider, and must comply with all applicable licensure standards, Titles of the Nebraska Administrative Code, and Nebraska State Statutes.

The DD provider agency must adhere to standards, as described in the Division of Medicaid and Long-Term Care Service Provider Agreement.

A provider delivering direct services and supports must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation; and
  - Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a legally responsible individual or guardian; and
- Not be an employee of DHHS.

The DD provider agency must have internet access in all settings that are provider operated or controlled for immediate adherence to applicable record-keeping and billing requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:

DHHS agency staff in combination with designated provider enrollment broker.
Frequency of Verification:
Direct support staff background check compliance is verified through the annual or biennial survey process. The provider enrollment broker ensures that revalidation of agency is completed every 5 years.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Service Coordination to waiver participants is provided by the Nebraska Department of Health and Human Services Division of Developmental Disabilities.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The requirement of obtaining background and/or criminal history is outlined in Neb. Rev. Statute 83-1217.01 and 404 NAC 4-004.03B and below.

a) The types of positions for which such investigations must be conducted: Certified DD agency providers must complete annual background and/or criminal history checks on each employee or contractor associated with the DD agency that has direct contact with individuals served by the agency.

b) The scope of such investigations: The state and federal background and/or criminal history checks consist of a review of the following:
NDEN - Nebraska Data Exchange Network for state and federal law enforcement history
SOR -Nebraska State Patrol Sex Offender Registry
DHHS APS and CPS Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse (physical, verbal, psychological or sexual), and if applicable, verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states
OIG LEIE - Office of Inspector General List of Excluded Individuals and Entities
SAM - System for Award Management, formerly the Excluded Parties List System (EPLS)
SSDMF - Social Security Death Master File
NPPES - National Plan and Provider Enumeration System
MCSIS - Medicaid and CHIP Information Sharing System
PECOS - Provider Enrollment, Chain, and Ownership System
SAVE - Systematic Alien Verification for Entitlements Program
NMEP - Nebraska list of excluded parties

Certified DD agency providers must complete annual background and/or criminal history checks on each employee or contractor associated with the DD agency that has direct contact with participants served by the agency. Initial background checks must be conducted by providers within ten calendar days of their employment and annually thereafter to verify a staff person or associated individual provider is not on the registries. Employees who provide direct support services may not work alone with participants until the results of the registry checks and background and/or criminal history checks are reviewed by the provider.

c) The process for ensuring that mandatory investigations have been conducted: On-site certification review activities conducted by Division of Public Health (DPH) staff ensure that required background and/or criminal history checks have been conducted by the DD provider agency. Provider management personnel are interviewed and records are reviewed to confirm that employee and associated individual provider background and/or criminal history checks were completed. In addition, DPH staff review documentation of provider hiring decisions to verify adherence to applicable state regulations. Annual or biennial on-site certification review activities are the same activities and the frequency is based on the provider's certification status, which is either a one-year certification or a two-year certification.

Once the background and/or criminal history checks are completed on potential providers, the contracted vendor notifies DHHS staff by e-mail and electronically transfers the enrollment data. The vendor will notify DHHS if a potential provider fails a screening or background check and designated DHHS staff will issue a denial letter to the potential provider. The electronic enrollment data contains the verification and dates that the background and/or criminal history checks were completed and is stored in perpetuity.

In addition, DHP staff review records to ensure that certified providers are in compliance with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The entity (entities) responsible for maintaining the abuse registry. The DHHS Adult Protective Services (APS) and Child Protective Services (CPS) Central Registries are maintained by employees of DHHS. The registry screenings are conducted by DHHS staff or a vendor under contract with DHHS, and consist of a check of the Nebraska State Patrol Sex Offender Registry (SOR), as well as the DHHS Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse (physical, verbal, psychological or sexual).

b) The types of positions for which abuse registry screenings must be conducted.
State Service Coordinators, Community Coordinator Specialists, and all waiver providers who will provide direct contact services and supports, and any member of the provider's household if services will be provided in the provider's home undergo the abuse registries listed in a) above.

c) The process for ensuring that mandatory screenings have been conducted.
On-site certification review activities conducted by Division of Public Health (DPH) staff ensure that required the abuse registry screenings listed in a) above have been conducted annually by the DD provider agency. Provider management personnel are interviewed and records are reviewed to confirm that employee and associated contractor registry screenings were completed. In

addition, DPH staff review documentation of provider hiring decisions to verify adherence to applicable state regulations. Annual or biennial on-site certification review activities are the same activities and the frequency is based on the provider's certification status, which is either a one-year certification or a two-year certification.

A provider agreement is not issued prior to completion of background and/or criminal history checks and registry screenings.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- (●) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A legally appointed guardian of a participant may not provide services to a person residing, being under care, receiving treatment, or being housed in any such home, facility, or institution within the State of Nebraska. (Neb. Rev. § 30-2627 Nebraska Probate Code)

A legally responsible relative is the parent of a minor child or the spouse of the waiver participant. There are no limits on the types of non-legally responsible relatives who may furnish services. Any potential provider meeting service standards has the right to be a provider. Non-legally responsible relatives may furnish services as specified in Appendix C in the service definitions, scope and limitations in accordance with provider standards outlined in Appendix C-1/C-3.

Provider agencies may hire relatives to provide waiver services when the relative is qualified and trained to provide the service in accordance with provider standards outlined in Appendix C-1/C-3. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered and for the services, activities and supports specified in the service plan.

The services for which non-legally responsible relative providers may provide include: Transportation, Prevocational service, Supported Employment-Individual, Supported Employment-Follow Along, Adult Companion service, Habilitative Community Inclusion, Assistive Technology, Home Modifications, Transitional services, Community Living and Day Supports, and Respite. Community Living and Day Supports will only be available under this waiver until September 30, 2017, and at such time this service will end and cannot be provided.
The State makes payment to non-legally responsible relatives when it is determined the provider meets and maintains all standards and requirements outlined in applicable state regulations.

Payment to any non-legally responsible relative provider shall only be made when the service provided is not a function that the relative would normally provide for the participant without charge as a matter of course in the usual relationship among family members; and, the service would otherwise need to be provided by a qualified provider. The provision of services by the non-legally responsible relative is determined through documented team discussion during the planning process, on a case by case situation by the participant's service plan team. The provision of services is monitored by the participant's state DDD Service Coordinator or Community Coordinator Specialist. The SC/CCS monitors at a minimum, on a semi-annual basis that services are furnished and paid for as specified on the ISP.

To ensure the provision of services is in the best interest of the participant, the service plan shall be developed and monitored by the SC/CCS without a conflict of interest to the relative provider, and the plan shall document that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Designated DDD staff ensures payments are made only for services rendered by prior authorizing all services based on the participant's needs and by reviewing submitted billing documentation.

Determination that the above circumstances apply is determined by the participant and his/her team and verified during enrollment of the potential independent provider.

The State does not make payments:

To members of the participant's immediate household for home modifications, respite and homemaker services; to a legally responsible relative/guardian; or for activities or supervision for which a payment is made by a source other than Medicaid.

There are no additional limitations on the amount of services just because the provider is a relative.

The following controls are in the web-based case management and authorization system to ensure payments are made only for services rendered:
The need for the service is documented in the individual service plan;
The provider is a Medicaid provider and enrolled prior to the delivery of waiver services;
DHHS staff have prior authorized each waiver service to be delivered;
At the time that services are delivered, documentation is completed by the provider to support the delivery of the service, such as, but not limited to participant attendance records and agency staff time cards;
A claim and when applicable, supporting documentation, is electronically submitted to DHHS for approval and processing;
An Explanation of Payment is issued electronically; and
Edits are in place in the electronic systems.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All willing and qualified providers have the opportunity to enroll as waiver service providers. DD services are provided by agencies that successfully completed an enrollment process through two divisions of the Department of Health and Human Services (DHHS); Public Health (PH) Division and Developmental Disabilities (DD) Division and through the contracted enrollment provider broker.

The enrollment and certification requirements and procedures, and established timeframes are readily available to prospective DD agency providers on the DHHS public website.

Information for becoming an independent provider can be obtained from the waiver participant, his/her advocate, his/her legal guardian, or DHHS staff as well as on the DHHS website.

Participants, his/her advocate or his/her legal guardian interview the potential provider to determine whether the amount of experience, knowledge, and education or training will meet their needs. The potential provider is referred to DHHS staff for enrollment. All willing and qualified independent providers can enroll.

DHHS staff and a vendor under contract with DHHS, are responsible for enrolling independent providers as waiver providers. Within two business days of receipt of a referral, DHHS staff enter the referral into the provider data management system for the enrollment process. An application number needed for access to the vendor web portal for enrollment is generated and DHHS staff send a referral packet to the potential provider. The referral cover letter advises the potential provider of the need to provide verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states. Verification of out of state background checks must be uploaded into the vendor's web portal before the provider can enroll. The referral packet includes billing information, an application number and instructions on how to use the contracted vendor's web portal to enroll, as well as a DD provider handbook, which contains general provider standards, specific service provider standards, and DD billing instructions. The potential provider completes the enrollment process with the contracted vendor on line or, if requested, on paper. The vendor notifies the referring DHHS staff by e-mail and electronically transfers the enrollment data to DHHS. Within ten business days, DHHS staff contact the prospective independent service provider to complete and issue a service provider agreement.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of enrolled licensed, certified providers that initially met provider standards prior to furnishing waiver services. Numerator = number of enrolled licensed, certified providers that initially met provider standards; Denominator = number of newly enrolled licensed, certified providers reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of enrolled certified providers that met provider standards at annual review. Numerator = number of enrolled certified providers that met provider standards at annual review; Denominator = number of enrolled certified providers reviewed that have had an annual review.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence internal with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new enrolled non-licensed, non-certified providers that met required background checks prior to furnishing waiver services. Numerator = number of new enrolled non-licensed, non-certified providers that met provider standards; Denominator = number of new enrolled non-licensed, non-certified providers reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
The Request for Service Provider Approval form of the Provider Background Results form

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of enrolled non-licensed, non-certified providers that met provider standards at annual review. Numerator = number of enrolled non-licensed, non-certified providers that met provider standards at annual review; Denominator = number of enrolled non-licensed, non-certified providers reviewed that have had an annual review.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Service Authorizations

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of all provider staff who successfully completed the required training. Numerator=number provider staff who successfully completed the training; Denominator=number of provider staff reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records reviews, off-site OR Training verification records

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Activities for the determination of compliance with the above sub-assurances and performance measures are completed by DHHS staff and a vendor under contract with DHHS. Monitoring of the delivery of services is conducted by the Service Coordinator (SC/CCS) or Community Coordinator Specialist (CCS) with input from the participant and/or representative when applicable.

Enrollment of qualified providers is completed by DHHS staff and the contracted vendor. DHHS has the ultimate responsibility for enrolling qualified providers and the execution of Medicaid provider agreements. Each DD provider agency is certified prior to furnishing waiver services in accordance with state regulations and re-certified on an annual basis.

DDD contracts with certified DD provider agencies for services under this HCBS waiver and enters into a provider agreement with non-certified independent providers. All providers of waiver services must be Medicaid providers, as described in the Title 471 regulations, and adhere to the same general conditions and standards. Failure to meet the regulatory requirements may result in termination or suspension of the provider agreement. Signing the provider agreement does not constitute employment.

Once DHHS approves the provider (Medicaid provider agreement and authorizations in place), web-based training for the provider is available, based on the provider type (independent or agency) and service type. Once enrolled, each independent provider of participant directed services is trained and directed by the waiver participant and/or their families.

The CBS QI committee meets quarterly and reviews the CBS Quarterly QI Report. The Report is comprised of indicators presented in nine separate categories. Indicators are short reports that measure and evaluate overall service delivery and organizational functions that affect individual outcomes. Indicators incorporate quantitative and qualitative methods to evaluate a number of key focuses developed by the Developmental Disabilities Division (DDD) in the areas of Rights, Habilitation, Financial, Service Needs, Health & Safety, Environment, Service Coordination, Provider Monitoring (General event Reports or GERs), and the Waivers. Recommendations are made for action by appropriate parties, including DDD management, members of the

committee, and other DHHS staff. The QI activities of DDD and results of reports are communicated by DHHS to provider organizations, the DDD Advisory Committee, the Nebraska DD Planning Council, and to participants, families, and other interested parties.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
A number of activities and processes at both the local and state levels have been developed to discover whether the Qualified Providers waiver assurance is being met, to remediate identified problems, and to carry out quality improvement. These processes and activities generate information that are aggregated and analyzed to measure the overall system performance.

The quality management strategies for addressing individual problems related to qualified providers are completed at the local level.

When an issue with performance of an independent provider is identified, a plan to address the issue is discussed by the SC or CCS with the participant and family/advocate or with only the provider, depending on the issues that need to be addressed, and documented by the SC/CCS. The participant may address the provider or may ask their SC/CCS to assist in addressing the concerns or issues with the provider. The SC/CCS will follow through with the participant or on behalf of the participant until the issue is resolved. The issue, discussion, and resolution are documented and retained in a web-based case management system.

The SC/CCS is responsible for facilitation and development of the service plan and then monitoring the implementation of each service plan in its entirety twice annually in addition to the ongoing monitoring of the service plan which may involve specific areas of the service plan within each monitoring session. The monitoring data is documented and retained in a web-based case management system.

Monitoring mechanisms include:
1. A review of all components of the service plan to ensure delivery of services as specified by the service plan;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the service plan is necessary; and
3. A semi-annual review of the service plan by the service coordinator and the service plan team. The team reviews progress, implementation of the service plan, and the need for any revisions to the service plan.

The monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC/CCS conducts ongoing monitoring in the environment that waiver services are provided when there are reports of abuse or neglect, health and safety concerns, at the request of the parent or guardian, or any other time when the SC/CCS determines it is necessary to monitor the service delivery. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring. If utilized, the effectiveness of back up plans for the provision of services is also monitored.

Waiver participants may ask for assistance from their SC/CCS in communicating to their independent providers their expectations, compliments, areas that need improvement, concerns, unacceptable practices, etc. The SC/CCS may increase monitoring activities, participate in discussions with the participant and provider, provide talking points, facilitate revisions to the service plan, or, upon direction from the participant, terminate the authorizations for that provider.

When a pattern of inappropriate or inaccurate claims is detected, a referral is made to the DHHS Program Integrity Unit.

In addition, the SC/CCS monitors the implementation of each service plan in its entirety twice annually in addition to the ongoing monitoring of the service plan which may involve specific areas of the service plan within each monitoring session. The data are entered into a database, summarized, and reviewed by the DDD QI Committee quarterly. The summarized data for the service plan review and implementation data summary are shared with service coordination staff at the local level, providers and DDD Central Office staff.

The quality management strategies for reviewing qualified providers are completed at the state level. The CBS QI Committee meets on a quarterly basis and reviews aggregate data for local, district, or statewide monitoring and certification to identify trends related to specific individual and agency providers and recommends resolution and/or changes that will support service improvement.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or more frequently as determined by the DDD Director.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

a) The waiver services to which the limit to the prospective budget amount applies:
The state has developed and implemented a methodology that determines a specific budget amount that is uniquely assigned to each individual waiver participant. The assigned budget amount constitutes a limit on the overall amount of services that may be authorized in the service plan. The limit on the maximum dollar amount of waiver services for each specific participant is individually objectively assessed and is a realistic estimate of the expected amount of services that waiver participants are likely to require. The individual budget amount (IBA) is the total annual funding amount available to the participant per their waiver year and is determined by DDD staff. The amount that is assigned is determined in advance of the development of the participant's service plan. The process for the determination of the individual budget amount is described in a printable public guidance document posted on the DDD public web page, and is also available in printed format at local offices. Each individual's budget amount and specific IBA is not disclosed as part of public inspection.
b) The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject.
The determination of prospective individual budgets for participants is determined using the 'Objective Assessment Process' or OAP as stated in statute and regulations. Funding is assigned based on an objective assessment of each participant's abilities, to provide for equitable distribution of funding based on each participant's assessed needs. Geographic factors do not affect the budget amount and the participant location is not factored into the objective assessment process.

The assessment to ascertain each participant's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). Division staff complete the ICAP assessment with input from the participant's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation to support tabulated responses. Substantiating documentation includes but is not limited to medical reports, psychological evaluations, critical incident data, and programmatic data. The completed ICAP assessment is submitted to the DDD Central Office where it is electronically entered to determine the overall score. The objective assessment process is completed for persons new to services and every two years thereafter.

The participant's 's service coordinator or community coordinator specialist is informed of the prospective individual budget amount and shares this amount with the participant and their family or legal representative at the time of initiation of DD services and in the development of the service plan via the service budget authorizations.
c) How the limit will be adjusted over the course of the waiver period.
The prospective individual budget amount is adjusted during the period the waiver is in effect. The limit will be adjusted to take into account cost increases, and the methodology will be periodically re-evaluated in light of changes in utilization patterns or other factors.
The participant's IBA will be adjusted when the two-year ICAP assessment score results in a change in the level of service need or sooner if a new ICAP was required by changes in the participant's health and welfare needs.
d) Provisions for adjusting or making exceptions to the maximum annual budget based on participant health and welfare needs or other factors specified by the state.
An ICAP is completed every two years, or sooner to address concerns in changes in a participant's health and welfare needs, and as approved by the Division. The individual budget amount is adjusted based on the result of the ICAP score. An ICAP may be requested to be completed sooner when a participant's needs have changed and cannot be safely met with funding solely based on the current prospective individual budget amount. Based on input from the participant, provider, and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request a new ICAP.

Alternative compliance to the funding tier, may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Service coordination staff complete risk screens related to Health, Physical Nutritional Management or Enteral Feeding (as applicable), Spine and Gait, and Behavioral needs. Based on input from the participant, provider, and guardian, if applicable, the team may submit a rationale for consideration to alternative compliance to the participant's ICAP score and identified tier level. A clinical review will be completed based on the alternative compliance request.
e) The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs.
The State has established the following safeguards to avoid an adverse impact on the participant:

Additional requests for services would be participants evaluated by the Division of Developmental Disabilities to determine if they are a critical health or safety need and is so would be approved based on available waiver funding. If no additional waiver funding is available, that is the expenditures have exceeded cost neutrality for the waiver, the following safeguards would be applied.
The participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs; or
The participant will be evaluated to determine if their needs and eligibility more closely align with other Nebraska waiver programs and will be assisted in the application process as deemed necessary.

f) How participants are notified of the amount of the limit.
Participants are notified in writing by Division staff their individual budget amount as well as the dollar limits of waiver services at the time of initiation of DD services and in the development of the service plan via the service budget authorizations. The written notice is mailed and includes hearing rights information.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2 of this waiver renewal for additional information.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Support Plan, hereafter referred to as service plan.

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:

A Service Coordinator (SC) or Community Coordinator Specialist (CCS) (case manager) is responsible to coordinate and oversee the delivery of effective services for participants through assessment, service plan development, referral, and monitoring activities. The SC/CCS makes referrals and coordinates related activities to help a participant obtain needed habilitation services, medical, social, educational providers, or other programs and services, and may make referrals to providers for needed services and schedule appointments for the participant. The SC/CCS completes monitoring and follow-up activities with the participant, family members, providers, or other entities to ensure that the service plan is effectively implemented and adequately addresses the needs of the participant, and whether there are changes in the needs or status of the participant that warrant making necessary adjustments in the service plan and service arrangements with providers. The SC/CCS serves as a liaison for the participant and family with service providers and the community. SC and CCS services are provided as Targeted Case Management under the Medicaid State Plan. The responsibilities for service plan development, implementation, and monitoring are the same for the SC and CCS.

The qualifications of a SC are as follows:

1. Bachelor's Degree required in: education, psychology, social work, sociology, or human services, or a related field.
2. Experience in services or programs for persons with intellectual or other developmental disabilities.
3. Ability to: mobilize resources to meet individual needs; communicate effectively to exchange information; develop working relationships with individuals with intellectual or developmental disabilities, their families, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; monitor services and supports provided; apply Department of Health and Human Services (DHHS) and program rules, policies, and procedures; and organize, evaluate and address program/operational data.
4. Knowledge of: current practices in the field of community-based services for persons with intellectual disabilities and other developmental disabilities; person-centered planning; Americans with Disability Act (ADA) standards; self-direction; community integration; the principles of social role valorization; provision of habilitation services; positive behavioral supports; and, statutes and regulations pertaining to delivery of services for individuals with developmental disabilities.
5. Knowledge of: the program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities (DDD); regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; State statutes regarding persons with disabilities; and DHHS programs, such as Protection and Safety and public assistance programs.

The qualifications of a CCS are as follows:

1. Bachelor's degree in education, psychology, social work, sociology, human services, or a related field.
2. Experience in services or programs for persons with intellectual or other developmental disabilities.
3. Ability to: mobilize resources to meet individual needs; communicate effectively to exchange information; develop working relationships with individuals with intellectual or developmental disabilities, their families, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; monitor services and supports provided; apply Department of Health and Human Services (DHHS) and program rules, policies, and procedures; and organize, evaluate and address program/operational data.
4. Ability to: assess the needs of persons with intellectual or other developmental disabilities; evaluate assessments; determine eligibility of individuals; develop and assess individual habilitative program plans and individual family support plans; adjust services as needed; mobilize resources to meet individual needs; interact and communicate with federal surveyors, other regulatory bodies and others in person via telephone, electronically, and written correspondence to exchange information and to respond to information requests; report non-compliance to appropriate agencies; develop working relationships with individuals with intellectual or developmental disabilities, their families and guardians, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; conduct formal assessments; monitor services provided; apply agency and program rules, policies, and procedures; think critically; and, organize, prioritize, evaluate and address program/operational data.
5. Knowledge of: current practices in the field of community-based services for persons with intellectual disabilities and other services for persons with developmental disabilities; person-centered program planning; basic medical terminology; the principles of social role valorization; provision of habilitation services; and positive behavioral support techniques.
6. Knowledge of: the program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities; regulations governing the authorization, delivery and payment of community-based developmental disabilities services; Department of Education regulations; State statutes regarding persons with disabilities; and DHHS programs, such as Protection and Safety and public assistance programs.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The participant's SC or CCS provides support to the participant to actively lead in the development of their service plan. The participant also has the option to direct their service coordinator to facilitate the service plan development meeting so that the participant may actively participate as a team member.

a) The supports and written information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process.

Prior to the ISP meeting(s), the Service Coordinator works with the participant to coordinate invitations and ISP/Annual Review meetings, dates, times and locations. The process of coordinating invitations includes the participant's input as to who to invite to the meeting(s) and at times and locations of convenience to the participant.

Service planning teams are comprised of people who care about and know the participant. The development process is a collaborative process between the participant and Service Coordinator that includes people chosen by the participant, provides necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions, and reflect cultural considerations and communication needs of the participant. The participant is present, is encouraged and assisted to participate in every aspect of their service planning as fully as they are able and choose to do so.

The SC/CCS, legal guardians and other participants chosen by the participant (e.g. representatives, family members, providers of service, advocate, specialist, and/or any relevant consultant) participate in the ISP process or parts of the ISP process. Participation includes a copy of the Services Handbook developed by the Division of Developmental Disabilities, reviewing and discussing the needs assessments and identification of health and safety risks; indicate service preferences; helping plan for the future and contributing to supports that will help the participant have the life they want; reviewing and approving the ISP and other documents by signing the ISP; communicating objections to the ISP; and approving changes or modifications to the ISP or support documents throughout the year, if needed.

b) The participant's authority to determine who is included in the process.

Persons eligible for DD services have a service plan developed prior to the initiation of waiver services. This person-centered plan is individually tailored to address the unique preferences and needs of the participant. Participants in the planning process will be determined by the participant and the legal representative, but must at least include the participant, representatives of their prospective DD provider(s), the SC/CCS, and the legal representative if there is one. The participant may raise an objection to a particular provider representative and the service plan team must attempt to accommodate the objection while allowing participation by provider representatives.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Who develops the plan, who participates in the process, and the timing of the plan.

Persons eligible for waiver services have a service plan developed prior to the authorization of the initial service package and annually thereafter. Service planning begins no later than 30 days following the eligibility determination with an Individual Family Meeting (IFM) where the SC facilitates the development of a personal focus worksheet with the participant and their family/legal representative. The purpose of this meeting is to gather information about what is important to and for the participant and what supports they need to be safe and healthy while leading the life of their choosing. This meeting is also the opportunity for the SC to explain the participant's individual budget and the available service array, including provider options. Within 45 days of the IFM, the team meets to develop the service plan. This person-centered and self-directed plan is individually tailored to address the unique preferences and needs of the participant. The purpose of the annual service plan meeting is to determine waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the participant to achieve their future plan, or personal goals.

Participants in the planning process are determined by the participant and/or the family or legal representative, if applicable, but must at least include the participant, the SC/CCS, the legal representative if there is one, and DD provider agency representatives when agency-directed services are provided. The service coordinator/CCS is responsible for scheduling, coordinating, and documenting all service plan meetings, and facilitating the participation of all team members by request of the participant. The SC/CCS elicits and records facts and information from other team members, advocates for the participant, encourages team members to explore differences and discover areas of agreement so that consensus can be reached, documents the service plan and the specific responsibilities of each team member with regard to implementation of services, supports, and/or strategies, and adheres to the electronic processes for service plan development and authorization. Meetings are scheduled at a time and place that accommodates the needs of the participant, the legal representative of the participant (if applicable), the parent(s) (if the participant desires parental involvement in the process), and the chosen advocate of the participant (if applicable). Dates for regularly scheduled service plan meetings are scheduled well in advance to assure attendance by all team members. The participant and/or family receiving services or any other team member of the interdisciplinary team may request a team meeting at any time.

Each participant also directs, with support as needed, their semi-annual service plan. The purpose of semi-annual service plan meeting is to review the implementation of the annual service plan, to document the participant's future plans and personal goals, to explore how the team can assist the participant to achieve those goals, to determine what information is needed to develop appropriate supports to assist the participant to achieve future plans, to assign responsibility for gathering information if needed, and to review any other issues which have impact on the participant's and/or family's life.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences, goals and health status.

The service plan must identify the needs, goals and preferences of the participant and specify how those needs, goals and preferences will be addressed. In order to accomplish that, assessments to evaluate the participant's strengths, capacities and areas needing growth to support the service plan development are determined by the team. These may include, but are not limited to, the Inventory for Client and Agency Planning (ICAP), psychiatric reports, psychological reports and assessments conducted by the provider to further their knowledge of the participant's skills and abilities (e.g., vocational, medication administration, home living skills, communicative intent of behavior, etc.).

Health and welfare is addressed through a variety of assessments that are completed by the provider, SC/CCS, the Education System, and/or Medical Professionals. Assessments include but are not limited to the Developmental Index, multidisciplinary reports, Individual Education Plan reports, medical evaluations, health screens, health assessments, General Event Reports (GER's) and environmental safety checklists.

Service Coordination/CCS staff are required to review completed GER's within 24 hours and follow up if necessary on health and safety concerns. Service Coordination/CCS staff are also mandatory reporters to Adult Protective Services and Children and Family Services when there is a significant health and safety concern. SC/CCS Supervisors are also required to conduct a stratified sample utilizing data stored in the DDD electronic records system as a means of doing a second level review of the service plans completed to ensure all that health and safety concerns are addressed.

(c) How the participant is informed of the services that are available under the waiver.

The participant is informed of the services that are available under the waiver prior to the initial plan development and annually thereafter at the pre-service plan meeting, also referred to as the Individual Family Meeting (IFM).

Additionally, written information, in the form of a Services Handbook, is provided by DDD SC/CCS staff to the participant, legal representative, and, as applicable, their family about services offered under the waiver program; the participant/guardian rights and obligations; due process rights; providers' roles and responsibilities; for applicable participant-directed service options - how to hire, fire and direct providers; and claims review and verification processes. The Services Handbook is provided to each participant and includes an introduction to the Division of Developmental Disabilities; an introduction to services; the roles and responsibilities of the participant and/or guardian, SC/CCS and provider; and service definitions. The Services Handbook also includes information about rights, responsibilities, and risks; developing a service plan; finding providers, including being given a list of available providers; hiring providers; training providers; working with providers; personal safety; and monitoring the service plan; the standards and qualifications providers are expected to meet; an introduction for providers, standards for specific services; and information on authorization and billing.

General information regarding service planning and service options are also available on the DHHS public website, within the Division of Developmental Disabilities tab, and by contacting DDD Central Office. However, the primary source of information for participants and families is received directly from SCs/CCSs, both verbally and in the written form described above prior to entry into the waiver services.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.

Prior to waiver entrance, an interdisciplinary team develops a detailed annual service plan through assessment, discussion, consensus, and assignment of responsibilities. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid resources. The annual plan includes, as appropriate:

- Employment goals and strategies when the youth is at least 16 years of age;
- Medical information;
- Nutritional considerations;
- As applicable, physical nutritional management plans;
- As applicable, adaptive devices, including support and protective devices;
- Physical and nutritional supports;
- Medical conditions and known allergies;
- Medications;
- Rights and rights restrictions;
- Legal needs;
- Finances;
- Identification of basic and other needs, which include:
  - Physical survival
  - Physical comfort
  - Emotional well-being/happiness and personal satisfaction
  - Personal independence and self-care;
- Requested service(s);
- Identification of current providers and a plan to locate needed provider(s), if applicable;
- Description and schedule of strategies, services, and supports to be provided, taking into consideration the participant's personal and career goals and identified needs;
- Identification of the prospective budget amount and the projected monthly cost/utilization of the services and supports to be provided, as well as services and supports to be provided by other non-DD funded resources; and
- Back-up plan, for each participant-directed service, in the event participant-directed services can't be provided or aren't provided as scheduled.

The service plan must identify the needs and personal preferences of the participant and specify how those needs and personal preferences will be addressed. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid resources. The service plan indicates how the team believes that this plan will meet the health and safety needs of the participant. These needs may be met by a combination of agency DD services/supports, participant-directed supports, natural supports, services/supports from other DHHS programs and other services/supports from other non-Medicaid sources. If it is determined that the needs cannot be met under the current plan without posing a

threat to the health and safety of the participant, the team will re-consider the appropriateness of the participant's service array and funding source. This may require referral to other services or programs and the development of an alternate plan.

(e) How waiver and other services are coordinated.

Coordination of waiver services includes documentation, referral, and follow-up. The SC/CCS is responsible for coordination and oversight of the delivery of effective services for participants through assessment, service plan development, referral, and monitoring activities. The participant and legal representative, and as applicable, their family determines the level of coordination desired. The SC/CCS may make direct referrals and coordinate related activities to help a participant obtain needed habilitation services, medical, social, educational providers, or other programs and services, and may make referrals to providers for needed services and schedule appointments for the participant. The SC/CCS may provide information about referrals and resources to the participant, legal representative, and as applicable, their family.

The SC/CCS completes monitoring and follow-up activities with the participant, family members, providers, or other entities to ensure that the service plan is effectively implemented and adequately addresses the needs of the participant, and whether there are changes in the needs or status of the participant that warrant making necessary adjustments in the service plan and service arrangements with providers. When requested, the SC/CCS may serve as liaison for the participant and family with service provider and the community.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.

The service plan document identifies the services and supports, schedule of delivery of services and supports, and responsibilities to implement the plan. The SC/CCS Supervisor ensures that the service plan addresses the participant's goals, needs (including health care needs), and preferences by reviewing and approving a stratified sample of annual service plans and annual budgets.

DD provider agency representatives must participate in development of the service plan and take the necessary steps to ensure that the service plan documents the team review, discussions, and decisions. The service coordinator/CCS is responsible for monitoring the implementation of the plan by observing and documenting observations on the service plan monitoring form. Monitoring is completed at a minimum, within 60 calendar days following the first day of implementation of the annual service plan and within 60 calendar days following the semi-annual meeting. SC/CCS staff also complete ongoing monitoring in the environment that waiver services are provided when there are reports of abuse or neglect, health and safety concerns, at the request of the parent or guardian, or any other time when the SC/CCS determines it is necessary to monitor the service delivery.

(g) How and when the plan is updated, including when the participant's needs change.

At a minimum, the team comes together annually to develop the service plan, and semi-annually to review the service plan. The service plan is updated during the semi-annual service plan meeting, and when circumstances and/or needs change the service plan may be updated following discussion and agreement via an in-person, electronic, or written communication. DDD does not employ temporary or interim service plans; any changes to the service plan are done formally and with full team participation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Assessment is required at least annually in conjunction with development of the service plan to identify the preferences, skills and needs of the participant.

Strategies are developed by the team to address areas of risk that are identified through the assessment process. If, for example, it is identified through assessment that a participant has the need to have their blood pressure monitored, the team would determine the method for ensuring such monitoring and informal teaching may be provided to enable the participant to develop independence in the skills necessary to self-monitor. In addition to the informal teaching, the team would develop a strategy for inclusion in the service plan as a backup plan. The strategy specifies who will be responsible for monitoring the participant's blood pressure and how often it must be monitored.

The SC/CCS is responsible for including the following in every service plan:
• A description and schedule of waiver services and supports to be provided, taking into consideration the participant's goals, preferences and identified needs;
• The identified provider(s);
• A back-up plan, in the event services can't be provided or aren't provided as scheduled. Back-up plans may include a temporary increase in natural supports, hiring additional on-call providers, etc.;
• Documentation of how the team believes that this plan will meet the health and safety needs of the participant. These needs may be met by a combination of agency and participant-directed services, supports, and strategies; natural supports, or services and supports from non-Medicaid programs.

Further assessment may be required based on the outcome of initial assessment. If the team identifies an elevated risk to the participant's health and welfare due to a medical condition, additional steps must be taken to address behavioral or medical risk.

When the team has attempted to manage a behavior unsuccessfully or feel they don't have the information necessary to develop an appropriate behavior management plan, it may be appropriate for assistance from a DDD psychologist to be requested. If any of the following factors exist, a risk assessment should be considered after the team's attempts to manage the behavior have been unsuccessful:

1. The participant has committed at least one physical attack towards another person with intent to inflict severe physical harm; or three moderately aggressive acts which may be described as kicking, punching/hitting/slapping and/or shoving that does not cause severe harm to another person.
2. The participant has had sexual contact/conduct with a child or non-consenting adult or other vulnerable person; the sexual contact would include touching or fondling the person as well as physical penetration with a body part or implement or forcing that person to perform sexual acts on self.
3. The participant has committed severe property destruction with the potential for injury to others, including destruction by fire.
4. The participant has had illegal or unsafe social behavior towards others, including prostitution, confrontational theft or robbery, threatening another person with a weapon, kidnapping/false imprisonment, or child enticement.

The primary intent of a risk assessment is to help the team understand the variables which could increase risk so that the team can incorporate these into a habilitative behavior support plan to reduce risk. DDD central office management may determine that behavioral risk services are necessary and oversee the selection of a behavioral risk service provider.

Should a participant be identified as having high-risk health care needs, either at entry to the DDD program or at any time during services, the need for increased support to safeguard the participant's well-being will be determined by designated clinical staff at DDD central office. A referral is completed by the participant's service plan team, which may include the participant's physician, to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of DDD central office. If additional services are requested to support health and welfare, DDD central office may choose to assign a DDD Program Specialist RN to conduct a formal health assessment. Medical history, current medical evaluations, and a formal health assessment are considered and recommendations or direction are provided to the team regarding optimal elements to consider when selecting or preparing service environments and treatment options that will best mitigate risks identified and support the participant. DDD Central office management may determine that additional services are necessary and oversee the selection of appropriate service provider (s).

If it is determined that the needs cannot be met under the current service plan without posing a threat to the health and safety of the participant and/or others, the team may need to re-consider the appropriateness of the participant's current waiver services. Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports will be accessed as necessary to protect the participant's health and welfare. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case by case basis.

Additional funding may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. In the event of a temporary increased service need of the participant, the amount of exception funding is determined administratively based on clinical information provided by the team. The cost of provider supports to mitigate any risks identified in clinical assessments is added to the base funding determined by ICAP.

Back up arrangements for the delivery of residential or day habilitation services by the DD provider agency are described in the provider's policies and procedures. Each agency has on-call or substitute staff available when a staff person fails to appear for work. Agency staff and/or parents have contact information for the DD provider agency's Manager or Coordinator who is responsible for scheduling and assigning on-call staff. Information about back-up plans for the delivery of residential or day habilitation services is provided by the DD provider agency to the participant and family or legal guardian when the DD agency provider is selected and documented in the service plan. A back-up plan is required in each participant's service plan. The need for and type of back up is discussed at the service plan meeting and documented in the service plan. Consideration is given to the natural supports that may be available to fill in and the availability of other enrolled providers in the community who could deliver services. Multiple independent providers may be enrolled as back up or substitute providers.

DD providers are also expected to have disaster plans developed and documented so provider staff are aware of expectations during such a time. Such plans should include where services should be provided if a disaster occurs, what necessary materials or equipment is needed for specific health or behavioral needs, and who needs to be contacted in cases of emergency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Nebraska's services for participants with intellectual or developmental disabilities are voluntary, both for the participant and the provider. Choice of providers and services is based on mutual consent. Nebraska has regulations and processes in place to ensure participants are provided information about DD services and providers to facilitate informed decisions. DHHS offices are located throughout the state to provide a statewide system of service coordination. The DDD public website includes information about the Division's responsibilities, service coordination, services funded by the Department of Health and Human Services (DHHS) and DDD, certified DD provider agencies, and non-certified independent providers as well as links to other resources for individuals and families.

The SC/CCS provides the participant, and/or the family or legal representative, if applicable, information about or web addresses or links to local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD provider agencies, and non-certified independent providers.

Information about local community services and supports, and how to access available services is provided to participants who are determined to be eligible for DDD services at the time of eligibility determination and ongoing thereafter at service plan meetings and more frequently as needed. Answers4Families is an internet family information and resource center, developed by DHHS in partnership with the University of Nebraska Center on Children, Families, and the Law. Nebraska 2-1-1 is an internet and phone comprehensive database that can be used to find health and human services. E-mail discussion groups are available and the directory (Nebraska Resource and Referral System) includes over 8,000 providers of services and supports in the state. Feedback on the site can be given instantly, with corrections the next business day, and every resource is updated every six months.

Ready, Set, Go! is a web-based series of materials and resources intended to assist in making decisions about supports for young adults with intellectual or developmental disabilities as they move from high school to adult life.

Service coordination/CCS staff may assist the participant, family, and/or legal guardian to arrange interviews with potential providers. Service coordination staff may assist the participant, family, and/or legal guardian to arrange tours of potential DD agency providers. Families often draw from their personal networks of family members not living in the household, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students in order to select independent providers for participant-directed services.

When the participant is considering assistive technology and supports (ATS), home modifications, and/or vehicle modifications, the SC/CCS makes a referral to an approved provider to ensure that the referral is an appropriate referral, based on the service definition of the applicable service and the provider's established protocols. The ATS, home modification, and vehicle modification service includes:

• An assessment report, which is a summary of needs and current support; recommendations; cost estimate and cost coordination, if needed; and hiring and oversight of subcontractor;
• If applicable, documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
• Copy of signed subcontractor bill and signed consumer acceptance form; and
• Narrative summary.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Health and Human Services (DHHS) is the State Medicaid Agency for Nebraska, and the Division of Developmental Disabilities (DDD) is a Division of the Medicaid agency. All functions related to service plan approval are completed by DDD staff. All annual service plans are read and reviewed by the designated SC Supervisor within ten business days from the date the service plan meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare.
Service coordination staff, which is the Service Coordinator (SC) or Community Coordinator Specialist (CCS) is responsible for in-person, on-site monitoring of the participant's health and welfare and monitoring of the implementation of the service plan. Service Coordination staff also monitors to ensure that the participant resides and/or receives services in a setting that meets the HCBS regulations and requirements.

(b) The monitoring and follow-up method(s) that are used.
SCs/CCSs conduct monitoring ongoing and continuously via phone calls and onsite visits with participants, both at their homes and at service provision sites. Required minimum monitoring must occur within 60 calendar days after the start of the annual ISP year and within 60 calendar days after the Semi Annual ISP review meeting.

Monitoring can take the form of face-to-face meetings or telephone calls with the participant, guardian, involved family members, the advocate or contacts on behalf of the participant, reviews of paperwork, such as financial records, medication records, etc. A review of services may include a review of habilitative programmatic data, observation of habilitative programs being implemented, observation of interactions between staff and the person whose service plan is being reviewed and/or review of any other documentation or communication available to verify that the ISP has been implemented as written. A standardized DDD monitoring template is used by SCs/CCSs whenever they are conducting face-to-face monitoring.

Following annual and semi-annual service plans, a review of all components of the service plan is conducted to ensure:
a. Delivery of services, supports, and strategies in accordance with the service plan;
b. Access to waiver and non-waiver services identified in the service plan;
c. Free choice of provider(s);

d. Determination that services meet participant/family needs;
e. Effectiveness of back-up plans, if applicable and utilized;
f. Health and welfare;
g. Physical nutritional management; and
h. Other as applicable, i.e., physical nutritional management plans, adaptive devices, etc.

Follow-up and remediation process for issues discovered during monitoring:
Observations made during a review or "in passing" are documented. Concerns will be discussed with the provider support staff who is working with the participant. If at any time it is noted that supports or services are not being provided as noted in the service plan, the SC will speak directly to the provider staff on duty to reach a resolution. Anytime a concern is noted on the monitoring form, follow up is required. Follow up should occur with the provider agency on how to provide resolution or address the concern noted on the monitoring form. The follow up could occur by phone, written in a letter/email, or in person. The SC will document the follow up completed on the monitoring form and in that participant's case notes. The provider will have up to 10 calendar days to respond to the SC in writing.

If determined necessary, any of the following steps may be taken:
a. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the service plan is necessary.
b. Addressing concerns with the provision of services, including but not limited to delays in implementing any aspect of the service plan or failure to adequately implement the service plan as written.
c. When a pattern is detected of inappropriate or inaccurate claims by a provider, a referral is made to the DHHS Program Integrity Unit.

Should immediate safety concerns be evident, the concern will be expressed verbally to appropriate personnel to prevent the participant or others from being harmed. If it is necessary for the SC/CCS to intervene to ensure the health and/or safety of the participant, such incidents will be immediately discussed with the SC/CCS Supervisor. Suspected abuse or neglect will be reported to DHHS Adult Protective Services and Child Protective Services as appropriate. The SC/CCS will document health and safety concerns in the case notes and complete a General Event Report (GER) as necessary. Please refer to Appendix G for a detailed description of DDD's critical incident management system.

Service coordination/CCS observations during the delivery of participant-directed services are discussed with the participant and/or family, as appropriate, and the provider, as appropriate, as soon as possible, and followed through to resolution. If resolved at this level, resolution will be documented on the monitoring tool or in SC/CCS case notes. A team meeting may be called to respond to monitoring issues and to adjust the service plan if necessary.

Concerns that do not involve immediate threats to health and welfare are noted by SC/CCS staff during on-site or any interaction with the delivery of agency-directed services will be discussed with appropriate provider agency staff as soon as possible. If resolved at this level, the resolution is documented in the SC/CCS case note. If the issue is not resolved, the SC/CCS will complete a Service Review Memo and send it to the provider agency staff supervisor and the SC/CCS' supervisor (SCS). A response is requested within ten days from receipt of the memo.

When a written response is received, the SC/CCS will review it to ensure that the action taken will correct the problem. If the response is not adequate or no response is received, the SC/CCS will contact the person to whom the Service Review Memo was sent to find out the status of the response. If the response was inadequate, the SC/CCS may add comments made by the staff person to the response. If the response is still inadequate, the SC/CCS will copy the written documentation of noted concerns and send it to his/her immediate supervisor. If no response was received and the staff person indicates when a response will be sent, the SC/CCS will review the issue with their Supervisor to determine the necessity of contacting the supervisor of the provider agency staff responsible for making changes or corrections to alleviate the concerns. The SC Supervisor will notify the SC/CCS with the results of the contact and the SC/CCS will document in the narratives. The issues must be addressed in writing. A response within ten days will be requested if the issue has not been resolved. When a response is received, the Supervisor and SC/CCS will review the response to ensure that it meets the expectations in correcting the problem. If no response or an inadequate response is received, the SCS will copy the written documentation of noted concerns and send it to the Service District Administrator (SDA) or their designee.

The SDA or designee will contact the Area Director of the provider agency to develop a mutually agreed-upon plan of action. If no resolution is achieved, or if trends show that the problems are recurring (such as "no ongoing habilitation provided," "programs not run as written," "programs not run at all," etc.) the SDA or designee will inform the DDD Central Office of the problems. Central Office staff will review the concerns to determine what steps to take and will notify the SDA or designee. Central office staff may provide consultation/technical assistance to the DD provider agency, perform a focused certification or contract compliance review specific to the delivery of services to an individual or provider setting, or initiate the complaint process described in Appendix F as necessary.

During certification reviews conducted by the Division of Public Health (DPH) DD Surveyors, the service plan is reviewed using the Core Sample Record Audit and, if behavior support is a part of the service plan, the Core Sample Review Checklist will be used. Certification reviews are conducted annually, biennially, or more frequently as determined by DDD management staff.

In addition, the service plan is reviewed and updated annually to determine if the plan developed and implemented by the team continues to meet the participant's needs. Areas reviewed include but are not limited to health, safety, habilitation, community membership and personal goals. The service plan identifies services, supports, interventions and strategies to be provided by the DD provider agencies as well as services provided by participant-directed independent providers of DD services. When non-compliance issues are identified with the provider agency, the types of action that may be taken range from citing a deficiency to termination of the provider agency. The general action taken is a citation of a deficiency and the provider must provide an acceptable plan of improvement that addresses the issues cited for those participants identified in the sample as well as address the issue cited on a system level within the agency provider.

The information derived from monitoring the implementation of the service plan and review of the service plan is entered into a database. Designated DHHS staff members have access to the database and may query the data to identify problems and trends.

(c) The frequency with which monitoring is performed.
Service Coordination staff, the SC or CCS, will verify, through ongoing monitoring efforts, that the services and supports provided continues to be effective. The SC/CCS monitors the implementation of each service plan. This oversight has long been a part of the regulations, policies, and expectations regarding the role of service coordination in monitoring. In-person and on-site full reviews are conducted at least twice annually- one within 60 calendar days of the annual service plan being implemented, and the other within 60 calendar days of the semi-annual service plan meeting for each participant in services. Ongoing in-person and on-site monitoring is conducted between the full monitoring when there are reported health and safety concerns, reports of abuse or neglect and/or when requested by a parent and/or guardian, or any other time when the SC/CCS determines it is necessary to monitor the delivery of services. The current on-site monitoring tool is designed to review the implementation of the total service plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC/CCS conducts ongoing informal monitoring on-site and in-person. During each of these monitoring sessions, the SC/CCS may choose to scrutinize only those items that surfaced as concerns during the semi-annual monitoring activities to check that the concerns have been remediated. However, this does not obviate the SC/CCS from having the responsibility to ensure that service plan implementation, health and safety, environmental factors, personal well-being and issues related to community integration are adequate to meet the needs of the participant.

Because all monitoring forms are stored in the DDD electronic records system, SC Supervisors are able to, and do, conduct regular and routine trend analysis of monitoring data. At minimum, SC Supervisors must conduct a trend analysis of all recorded monitoring findings for each provider in their geographic service on a semi-annual basis. Threshold concerns are reviewed with the local DDD Field Office Administrator and brought to the attention of DDD Central Office Senior Field Office Administrator and the DPH licensing unit as needed.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1. Number and percent of participants reviewed for whom all personal goals have been addressed in the Service Plan. Numerator = number of participants for whom all assessed personal goals have been addressed in the Service Plan; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. Number and percent of participants reviewed for whom all assessed needs (including health and safety risk factors) have been addressed in the Service Plan. Numerator = number of reviewed participants for whom all assessed needs have been addressed in the Service Plan; Denominator = number of participants service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1. Number and percent of participants reviewed whose Service Plans were revised, as needed, to address changing needs. Numerator = number of participants whose Service Plans were revised, as needed, to address changing needs; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
2. Number and percent of participants reviewed whose Service Plans were reviewed and revised on or before the annual review date. Numerator = number of participants whose Service Plans were reviewed and revised on or before the annual review date. Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number & percent of participants reviewed whose service plan indicated services delivered in accordance with the specified type, scope, amount, duration and frequency. Numerator = number of participants whose service plan indicated services delivered in accordance with the type, scope, amount, duration and frequency as specified in the service plan. Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Participants Reviews

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants reviewed whose annual service plan documents that the participant and/or legal representative was provided with a choice of waiver services and providers. Numerator = number of participants whose annual service plan indicated participants were given a choice of providers and services; Denominator = number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In Nebraska, the service plan for participants of this waiver is known as the Individual Support Plan (ISP). The Service Coordinator (SC) or Community Coordinator Specialist (CCS) is responsible for facilitation and development of the service plan.

The SC/CCS Supervisor reviews the on-line initial service plan for each waiver participant to ensure it meets the waiver and regulatory standards. The process was developed to also ensure the service plan is completed in accordance with timelines and to aggregate the results to identify issues at various levels of the DDD.

The SC/CCS considers assessment information, the participant's personal goals, and the service plan to determine if the services defined flow from the assessments and personal goals. This on-line review includes not only the waiver services, but also the non-waiver services and other natural and community supports identified in the service plan.

If issues (e.g., institutionalized more than 30 days, loss of Medicaid eligibility, or failure to utilize waiver services) are identified by the system or DDD staff that will affect the waiver status of the participant, the SC/CCS is notified and addresses the issues. Failure to address the issues may result in the removal of the person from the waiver. Correction of the areas of concern may allow the participant to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver support. Other issues that do not effect waiver funding are available to the SC/CCS responsible for the development of the service plan and their supervisor in reports in the web-based case management system.

To allow for increased state oversight of the service plan review process, the responses are entered into a database in the web-based case management system. The database allows for SC/CCS Supervisors and DD staff responsible for program accuracy reviews and QA/QI to have access to the information in aggregate form to look at the performance of individual SCs/CCSs. Quarterly on-site file reviews are conducted by Supervisors. The annual proportionate random sample size for on-site reviews is 8%. Additionally, DDD Central Office quality staff annually conduct off-site file reviews for an additional 3% proportionate random sample to verify the work of the field supervisors. The sample size is determined by 1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR 2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4.

In addition, the SC/CCS monitors the implementation of each service plan in its entirety twice annually in addition to the ongoing monitoring of the service plan which may involve specific areas of the service plan within each monitoring session.

Monitoring mechanisms include:
1. A review of all components of the service plan to ensure delivery of services as specified by the service plan;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the service plan is necessary; and
3. A semi-annual review of the service plan by the service coordinator and the service plan team. The team reviews progress, implementation of the service plan, and the need for any revisions to the service plan.

The monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC/CCS conducts ongoing monitoring in the environment that waiver services are provided when there are reports of abuse or neglect, health and safety concerns, at the request of the parent or guardian, or any other time when the SC/CCS determines it is necessary to monitor the service delivery. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the monitoring process, responses on the service plan monitoring forms are entered into a web-based database. This allows individual SCs/CCSs to track issues that are yet unresolved and provide aggregate information for SC/CCS Supervisors, program accuracy and/or QA/QI staff, and the DDD central office management. The information is useful for looking at the performance of individual SCs, CCSs, and providers, as well for identifying any area-wide issues. This information is reviewed and acted on, as appropriate, at the Field office level by a supervisor and/or administrator.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If financial eligibility issues are discovered that will affect the participant's waiver eligibility status, the SC/CCS is notified and given a date to respond. The date of response is determined by the SC/CCS supervisor and varies between 5 and 10 working days, based on the nature of the issue. Failure to receive corrections may result in the removal of the participant from the waiver, and correction of the areas of concern may allow the participant to be maintained on the waiver or to be put back on the waiver if they had lost their waiver status. There is no gap in services to the participant; services are funded by state general funds to ensure continuation of services, health, and safety.

The SC/CCS monitoring process is designed to review the implementation of the total service plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC/CCS conducts ongoing monitoring in the environment that waiver services are provided when there are reports of abuse or neglect, health and safety concerns, at the request of the parent or guardian, or any other time when the SC/CCS determines it is necessary to monitor the service delivery. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the monitoring process, responses on the service plan monitoring forms are entered into a web-based database. This allows individual SCs/CCSs to track issues that are yet unresolved and provide aggregate information for SC/CCS Supervisors, program accuracy and/or QA/QI staff, and the DDD central office management. The information is useful for looking at the performance of individual SCs, CCSs, and providers, as well for identifying any area-wide issues. This information is reviewed and acted on, as appropriate, at the local level.

When issues or problems are discovered during a SC/CCS monitoring, the participant's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the participant, manager of services, and/or providers, etc. A timeline to address the issues and/or a service plan team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

When a pattern is detected of inappropriate or inaccurate claims, a referral is made to the DHHS Program Integrity Unit.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) The nature of the opportunities afforded to participants:

The Division of Developmental Disabilities (DDD) embraces a self-directed philosophy, designed to provide choice when determining the services and supports that are needed to maximize the independence of the person with an intellectual or other developmental disability. The service coordinator (SC) or community coordinator specialist (CCS) is involved in supporting participant-direction. The SC/CCS supports participant-direction by meeting with the individual and family to facilitate discussion of the individual's budget, the participant-directed services available to the participant, and the rights and responsibilities associated with choosing participant-directed services. The SC/CCS may assist in locating independent providers and facilitate interviewing the perspective providers and may assist in setting up referral meetings with certified Developmental Disabilities (DD) provider agencies. The SC/CCS facilitates and documents the service plan meeting.

Opportunities for participant direction are available to participants that choose select DD services, listed in E.1.g. These services are services directed by the participant or advocate when one has been selected by the participant. An advocate may be either a family member or a trusted friend (this category will be referred to as "advocate" for the purposes of this section). Participant-directed services are intended to give the participant more control over the type of services received as well as control of the providers of those services. The underlying philosophy of offering participant-directed services is to build upon the individual and family strengths and to strengthen and support informal and formal services already in place.

(b) How participants may take advantage of these opportunities:

Persons eligible for waiver services participate in the development of their service plan prior to the initiation of services and annually, or more frequently as needed, thereafter. The purpose of the annual service plan meeting is to determine waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the participant to achieve their future plan, or personal goals. The purpose of semi-annual service plan meeting is to review the implementation of the annual service plan, to document the participant's future plans and personal goals, to explore how the team can assist the participant to achieve those goals, to determine what information is needed to develop appropriate supports to assist the participant to achieve future plans, to assign responsibility for gathering information if needed, and to review any other issues that affect the participant's and/or family's life. The participant receiving services and/or legal representative/advocate, or any other team member of the interdisciplinary team, may request a team meeting at any time between the annual and semi-annual meetings to update the service plan when circumstances and/or needs change. Should any of the participant's services be participant directed, and an advocate is assigned, then the advocate shall be invited to all planning meetings.

The participant has the right and responsibility to participate to the greatest extent possible in the development and implementation of their service plan. This person-centered service plan is individually tailored to address the unique preferences and needs of the person. Membership in the planning process is determined by the participant or their legal representative/advocate, if applicable, but must at least include the participant/involved family, the service coordinator, the legal representative/advocate, if there is one, and DD provider. The participant may take responsibility or direct their SC/CCS to be responsible for scheduling, coordinating and chairing all service plan meetings. The SC/CCS assists the participant or directly facilitates the participation of all team members. The service plan must identify the needs and preferences of the individual and specify how those needs will be addressed. This must include identification of services and supports to be provided as well as other non-DDD funded resources.

Participants and/or their legal representative/advocate have the right and responsibility to select potential providers. The participant and/or their legal representative/advocate identifies a potential provider and screens the provider to determine capability for delivery of services, based on the participant's needs and preferences, and the potential provider's experience, knowledge, and training, and the participant and/or their legal representative/advocate describes to the provider the supports to be delivered.

(c) The entities that support individuals who direct their services and the supports that they provide:

At any time, the participant or their legal representative/advocate can request assistance from their SC/CCS. The SC/CCS may complete the above steps, as directed by the participant and/or legal representative/advocate.

Once the provider is enrolled and prior authorized for delivery of services, the participant and/or legal representative/advocate directs the provider by setting the schedule and determining how the services will be delivered, and, based on the service plan, the type and amount of service.

The participant and/or their legal representative/advocate also has the authority to terminate the provider, by directing Department of Health and Human Services (DHHS) staff to end the authorization for the delivery of services. DHHS has the option to retain the contract to allow other individuals to utilize the enrolled provider.

The Internal Revenue Service (IRS) has approved DHHS to be appointed the Fiscal/Employer agent as a means to ensure all requisite IRS rules are being followed. DHHS provides the following services in this capacity:
(a) manage and direct the disbursement of funds contained in the participant-directed budget;
(b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the participant and/or legal representative/advocate and state authorities. As a state entity, DHHS is not required to file individual forms 2678 with the IRS. Instead, DHHS devised a substitute form 2678 (referred to as DHHS form FA-65) which DHHS entitled "Appointment of DHHS as Agent for State and Federal Employment Taxes and Other Withholding Taxes for In-Home Service." It is broader than the IRS form because it also allows DHHS to handle state employment taxes. This form is maintained by the service coordinator and kept in the participant's electronic file maintained by DDD. Information regarding IRS related responsibilities is explained verbally and in writing to the participant and provider. Under federal law, DHHS and the participant/Common Law Employer are jointly liable for employer taxes; however, neither entity is required to withhold income taxes.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one)*:

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Additional criteria that excludes participant-direction:
1) Person chooses only services that are provider managed services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction.

Information about participant-direction opportunities is available to participants who are currently receiving DD services as well as to any individual entering DD services. Information is provided verbally and through written materials provided by the SC/CCS or designated DDD staff, and is provided to the individual and legal representative/advocate, if applicable, prior to entrance to the waiver and prior to the annual service plan development meeting to allow sufficient time for the participant to weigh the pros and cons of participant-direction and obtain additional information as necessary. Information about participant-direction opportunities is available in a Service Directory, a Participant Handbook for Self-Direction, an informational QuickGuide, the DHHS website, and other public communications, such as information from Nebraska Department of Education about post-high school opportunities and information developed through the Nebraska DD Council.

The DHHS DDD public website also includes information about the Division's responsibilities, service coordination, services funded by DHHS and DDD, certified DD provider agencies, and non-certified independent providers as well as links to other resources for individuals and families.

The Services Directory, QuickGuide and Participant Handbook are utilized as a training tool and post-training reference guide for participants and their support system. The Participant Handbook includes a description of its purpose, an overview of services, and tips for determining the appropriateness of participant-directed services and supports, developing a plan, and putting the plan into action. The handbook also includes tips for finding the right provider, provider and service standards, participant liability, preparing for an emergency, and additional resources. Billing and authorization guidelines for providers and how to fill out and submit a claim are also included in the Service Directory.

(b) The entity or entities responsible for furnishing this information:

The SC/CCS and other designated DD staff provide the participant, and/or legal representative/advocate, if applicable, information about, or web addresses or links to, local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD provider agencies, and non-certified independent non-specialized providers.

(c) How and when this information is provided on a timely basis:

The provision of written information about participant-directed services and supports is an integral component of the development of the service plan. The participant's SC/CCS provides verbal and written information about participant-directed services and supports to participants and legal representative/advocates at entry into waiver services, annually thereafter, and as requested. The written information includes all information posted on the DDD website, for those who prefer written materials or do not have access to the internet.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appointment of an advocate is a voluntary appointment, and the representative is appointed by the participant only in the event that the participant does not have a legal representative. The responsibilities and extent of decision making authority exercised by the advocate is determined by the participant and their team and documented in the service plan. The advocate must be

19 years of age or older and can be a family member or trusted friend of the participant. The advocate provides assistance to the participant/Common Law Employer and works with the participant to make sure they are fulfilling their wishes and needs as desired, though they do not assume legal responsibility for the Common-Law employer's tax duties. Individuals interested in becoming an advocate are screened by the ISP team to ensure that they demonstrate a strong commitment to the participant's wellbeing and are interested in and able to carry out program responsibilities and to comply with program requirements.

Service coordination provides monitoring to ensure that the legal representative/advocate functions in the best interest of the participant as part of monitoring the service plan. The SC/CCS evaluates the ability of the legal representative/ advocate to represent the best interests of the participant, which includes ascertaining and acting in accordance with their preferences—unless they are impractical. If legal representatives/advocates serve their own interests rather than those of participants, the SC/CCS may make a report to protective services or contact legal advocacy organizations by phone or e-mail to advise that a change in legal representation/advocacy should be considered. In egregious cases, the state may require a change of legal representative/advocate or, if no other can be identified, require a transfer to traditional services.

The legal representative/advocate is prohibited from providing authorized waiver services to the participant and receiving reimbursement under the waiver.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Prevocational Services	☑	☑
Respite	☑	☑
Habilitative Community Inclusion	☑	☑
Adult Companion Service	☑	☑
Community Living and Day Supports	☑	☑
Assistive Technology	☑	☑
Transportation	☑	☑
Supported Employment - Follow Along	☑	☑
Supported Employment - Individual	☑	☑
Home Modification	☑	☑
Consultative Assessment Service	☑	☑
Environmental Modification Assessment	☑	☑
Transitional Services	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ **Governmental entities**
☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The state provides Government Fiscal/Employer Agent financial management services directly as an administrative activity.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The state has an approved cost allocation plan that includes administrative claiming for activities performed as the FMS. Medicaid and Long Term Care, a Division within the Medicaid Agency, is the Government Fiscal Employer Agent and claims FFP for the administrative activities performed as the FMS.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**
☑ **Collect and process timesheets of support workers**
☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☑ **Maintain a separate account for each participant's participant-directed budget**
☑ **Track and report participant funds, disbursements and the balance of participant funds**

- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Administrative Services (AS) State Accounting is responsible for systematically reviewing on a regular basis activities of state agencies and departments to determine that adequate internal controls exist within all Departments, including DHHS, to assure that proper accounting methods are employed, per Nebraska Revised Statues Section 81-111(4). State Accounting approves a required internal control plan for financial reporting that is implemented, tested and monitored by DHHS, which includes pre-audit functions. DHHS has an Internal Audit Division to perform internal audits along with assisting DHHS staff in the event of a State or Federal audit.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

- [x] **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case management in Nebraska is performed by DD Service Coordinators (SCs) and Community Coordinator Specialists (CCSs). All DD SC/CCSs are qualified to provide participant-direction guidance. In addition to the basic service coordinator training, DD SC/CCSs receive training on the self-directed services that are available, such as the types/definitions of services; limits on the amount, frequency, or duration; authorization codes and rates; billing guidelines; budget projecting; and the referral process for enrollment of independent non-specialized providers. The SC/CCSs also receive the Service Directory and Participant Handbook for Self-Direction as a training tool.

In addition to the basic service coordination duties performed by DDD service coordinators, the DDD SC/CCSs provide technical assistance to those who self-direct the waiver services listed in E-1-g. The SC/CCS will review the Service Directory with the participant and their representative, if applicable, to assist the participant in understanding their responsibilities in hiring, training, screening claims, and dismissing a provider, as well as assisting the individual to recognize potential abuse and neglect situations.

The SC/CCSs will provide the amount of funding available to the participant and develop the monthly budget with the participant and representative. When determining the rate for an independent provider, the SC/CCS and participant and/or representative develop the budget together. The participant is informed of their annual funding allocation and the range of rates to be considered, based on the potential provider's experience and training, and the participant's needs and tasks that the potential provider will perform.

If the participant has not chosen their provider(s), the SC/CCS may provide a list of currently enrolled independent providers for the participant to select from, and interview the potential provider with the waiver participant if the participant requests assistance. The SC/CCS follows through with DHHS staff responsible for provider enrollment to ensure that the provider is enrolled and authorized to provide the selected services to the participant.

If requested, the SC/CCS will assist the participant in communicating their expectations to the independent provider of what and how the services will be delivered as well as address any performance issues that may arise.

- [ ] **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modification	☐
Prevocational Services	☐
Respite	☐
Supported Employment - Enclave	☐
Habilitative Community Inclusion	☐
Day Habilitation	☐
Adult Companion Service	☐
Integrated Community Employment	☐
Behavioral Risk Services	☐
Community Living and Day Supports	☐
Assistive Technology	☐
Habilitative Workshop	☐
Medical Risk Services	☐
Retirement Services	☐
Team Behavioral Consultation	☐
Vocational Planning Habilitation Service	☐
Adult Day Services	☐
Transportation	☐
Supported Employment - Follow Along	☐
Workstation Habilitation Services	☐
Supported Employment - Individual	☐
Home Modification	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Crisis Intervention Support	☐
Consultative Assessment Service	☐
Environmental Modification Assessment	☐
Personal Emergency Response System (PERS)	☐
Transitional Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Nebraska's DD services are voluntary services for the participant as well as the provider. Each person's funding amount is based on an objective assessment process, and the funding follows the participant. Each participant or their legal representative/advocate can choose the types of services and the providers to meet their needs and preferences. The authorization of funding for services to a particular provider or providers is mutually agreed upon, and either entity can end participation. All DD providers are waiver providers.

Nebraska offers provider-managed services under this waiver and another HCBS waiver for adults with developmental disabilities. The participant and their legal representative/advocate may choose provider-managed services that may better meet their health and safety needs. The provider-managed waiver services are delivered by certified DD provider agencies and the team process is utilized in assisting the participant or legal representative/advocate in choosing waiver services and providers that may better meet their needs. Participants can receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

State regulations allow the state to deny or end funding of specific services when:
1. A participant's needs are not being met through waiver services or intensity of services and supports does not reflect the need for ICF level of care;
2. The participant or their legal representative has failed to cooperate with, or refused the services funded by DDD; or,
3. The participant's service plan has not been implemented.

The decision to end funding may be based on service coordination monitoring, review of the service plan, critical incident reports, and assessment of risk to the participant and/or community, and complaint investigations conducted by the DHHS staff.

Nebraska offers provider-managed services under this waiver and another HCBS waiver for adults with developmental disabilities. The participant and/or their legal representative/advocate may choose provider-managed services that may better meet their health and safety needs. The provider-managed waiver services are delivered by certified DD provider agencies and the team process is utilized in assisting the participant and/or legal representative in choosing waiver services and providers that may better meet their needs. Participants will receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		557
Year 2		642
Year 3		727
Year 4		812
Year 5		897

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☑ **Recruit staff**
- ☐ **Refer staff to agency for hiring (co-employer)**
- ☑ **Select staff from worker registry**
- ☑ **Hire staff common law employer**
- ☐ **Verify staff qualifications**
- ☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- ☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☑ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☐ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☑ **Determine the amount paid for services within the State's established limits**
- ☑ **Substitute service providers**
- ☑ **Schedule the provision of services**
- ☑ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☑ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☑ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☑ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The methodology for establishing the amount of the participant-directed budget is the same as for agency-directed services, as fully described in Appendix C-4.a. The state has developed and implemented a methodology that determines a specific budget amount that is uniquely assigned to each individual waiver participant. The assigned budget amount constitutes a limit on the overall amount of services that may be authorized in the service plan. The limit on the maximum dollar amount of waiver services for each specific participant is individually objectively assessed and is a realistic estimate of the expected amount of services that waiver participants are likely to require. The individual budget amount (IBA) is the total annual funding amount available to the participant per their waiver year and is determined by DDD staff. The amount that is assigned is determined in advance of the development of the participant's service plan. The process for the determination of the individual budget amount is described in a public guidance document posted on the DDD public web page. Each individual's budget amount and specific IBA is not disclosed as part of public inspection.

The determination of prospective individual budgets for participants is determined using the 'Objective Assessment Process' or OAP as stated in statute and regulations. Funding is assigned based on an objective assessment of each participant's abilities, to provide for equitable distribution of funding based on each participant's assessed needs. Geographic factors do not affect the budget amount and the participant location is not factored into the objective assessment process.

The assessment to ascertain each participant's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). Division staff complete the ICAP assessment with input from the participant's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation to support tabulated responses. Substantiating documentation includes but is not limited to medical reports, psychological evaluations, critical incident data, and programmatic data. The completed ICAP assessment is submitted to the DDD Central Office where it is electronically entered to determine the overall score. The objective assessment process is completed for persons new to services and every two years thereafter.

The prospective individual budget amount is adjusted during the period the waiver is in effect. The limit will be adjusted to take into account cost increases, and the methodology will be

periodically re-evaluated in light of changes in utilization patterns or other factors.

The participant's IBA will be adjusted when the two-year ICAP assessment score results in a change in the level of service need or sooner if a new ICAP was required by changes in the participant's health and welfare needs.

An ICAP is completed every two years, or sooner to address concerns in changes in a participant's health and welfare needs, and as approved by the Division. The individual budget amount is adjusted based on the result of the ICAP score. An ICAP may be requested to be completed sooner when a participant's needs have changed and cannot be safely met with funding solely based on the current prospective individual budget amount. Based on input from the participant, provider, and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request a new ICAP.

Alternative compliance to the funding tier, may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Service coordination staff complete risk screens related to Health, Physical Nutritional Management or Enteral Feeding (as applicable), Spine and Gait, and Behavioral needs. Based on input from the participant, provider, and guardian, if applicable, the team may submit a rationale for consideration to alternative compliance to the participant's ICAP score and identified tier level. A clinical review will be completed based on the alternative compliance request.

Additional requests for services for participants are evaluated by the Division of Developmental Disabilities to determine if they are a critical health or safety need and is so would be approved based on available waiver funding. If no additional waiver funding is available, that is the expenditures have exceeded cost neutrality for the waiver, the following safeguards would be applied:
1. The participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs; or
2. The participant will be evaluated to determine if their needs and eligibility more closely align with other Nebraska waiver programs and will be assisted in the application process as deemed necessary.

The original Objective Assessment Process methodology was developed in 1996 and public meetings were held at that time to explain the process. The process was upgraded in 2008 and a document describing the methodology and its improvements was prepared and made available to the public at that time. Since then, the public has been reminded of the process through public meetings and documents posted on the DDD website associated with rate setting improvements, in 2011 and again in 2015-2016. Additionally, all draft waiver appendices are posted on the DDD website and the public has had extensive opportunity to review the appendices and comment, both in an ongoing fashion and in the official Public Comment period for this waiver.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participants are notified in writing by DDD staff their individual budget amount as well as the dollar limits of waiver services at the time of initiation of DD services and prior to the development of the service plan. The participant is also notified of their service budget authorizations, prior to services being delivered. The written notice is mailed and includes fair hearing rights information. Questions about the right to a fair hearing are directed to the service coordinator or their supervisor. Additionally, the HCBS waiver manager at DDD is available to respond to participant questions regarding fair hearing rights as well as any other aspect of waiver implementation.

The participant and/or their representative may propose budget changes at any time, by either contacting the SC/CCS. By utilizing the electronic service plan, the overall impact of the change is calculated and the participant and/or their representative is able to make side by side comparisons of the proposed change. The service coordinator is then responsible for documenting the need for the change. The parameters of allowable waiver services are provided to each SC/CCS and available to each participant/family upon request. Paper submission and approval are available for participants who do not have internet access .

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards have been established to prevent the premature depletion of the participant's budget or address potential service delivery problems that may be associated with budget over-utilization. DDD is responsible for ensuring the implementation of safeguards developed for the participants who are self-directing. The vendor web-based authorization and case management system tracks budget utilization and provides monthly reporting to DDD service coordination, management, and administrative staff.

The DDD and the vendor developed business rules within the web-based system that will flag providers and service coordination of possible over-utilization. Provider claims cannot exceed the monthly authorized amount. If the provider's claim exceeds monthly authorized amount, the participant's DD Service Coordinator (SC) or Community Coordinator Specialist (CCS) must be notified by the provider through an electronic message. The participant and their SC/CCS discuss and manage adjustments to the monthly authorized amount as well as the annual budget amount if necessary.

Likewise, providers contact participants and their SC/CCS if services are underutilized. The SC/CCS may follow-up with monitoring, a meeting with appropriate parties, referrals to other another qualified waiver provider, participant education, provider re-education, and/or risk screenings to assess health and safety.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants are advised of their hearing rights at the time of initial eligibility by the Developmental Service Specialist and thereafter at the time of the Service Plan, facilitated by service coordination. At the annual Service Plan meeting, the participant or their legal representative as applicable is given a Notice of Rights and Responsibilities and signs the document. Hearing rights are also printed on the Notice of Decision.

Participants will receive a Notice of Decision in any of the following circumstances:

1. The applicant is determined ineligible for HCBS waiver services;
2. The applicant is denied HCBS services as an alternative to institutional care;
3. The participant's choice of provider is denied; or
4. Services to the participant are denied, reduced, suspended or terminated.

The Notice of Decision advises participants of their right to a hearing, the method by which to obtain a hearing, and that they may represent themselves or use an attorney, friend or other spokesperson when they begin receiving services and annually thereafter. This information is also posted on the public website at www.dhhs.ne.gov/developmental_disabilities.

The DDD Director or designee mails the Notice of Decision to the participant and the participant's legal representative at least ten days prior to the action being taken, in accordance with 42 CFR 431.211.

The Notice of Decision includes an advisement that services will continue (or be reinstated) if the participant requests a hearing within ten days of the mailing of the Notice of Decision.

Request for Fair Hearing must be submitted in written hardcopy or electronic form. All Notices of Decision and Requests for Fair Hearing are maintained in electronic form, in accordance with the Records Retention Schedule applicable to the Division of Developmental Disabilities (DDD). Fair hearing rights are provided in English and Spanish according to the language spoken at home on file and may be translated into other languages upon request.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Participants receiving supports through the waiver may register a grievance or complaint with the DDD and are informed that filing a grievance or making a complaint are not a pre-requisite or substitute for a fair hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) The types of grievances/complaints that participants may register.

Participants are advised in the annual Notice of Rights and Responsibilities (received at the annual Service Plan meeting) that filing a grievance or complaint is not a prerequisite for filing for a Fair Hearing.

Participants receiving supports through the waiver may register the following types of grievances/complaints:
1. Safety, endangerment, or welfare issues;
2. Suspicion of Medicaid fraud;
3. Violations by providers of Medicaid regulations, DDD regulations or policy by DDD/Medicaid providers;
4. Issues regarding pre-admission screening, pre-authorization, or fiscal management services;
5. Issues related to paid supports other than legal representatives, such as social worker, doctor, therapist;
6. Issues related to participant's service coordinator;
7. Difficulty with DD services and/or provider agencies.

b) The process and timelines for addressing grievances/complaints.

The grievance/complaint may be submitted via mail, email, and phone or in person at a local DHHS office. DDD also has a central phone number that participants can call to file a complaint or to ask questions. Participants can also write a letter and mail or fax it in to the DDD. All individual grievances/complaints are responded to within 24 working hours and logged using a system maintained by DDD. The DDD Director or designee will work with the appropriate groups to address the grievance/complaint. Complaints, questions or concerns are either responded to directly by DDD or referred to the Licensing Unit at the Department of Health and Human Services (DHHS) Division of Public Health (DPH), if appropriate. The Division of Public Health provides certification and licensing services to individuals, agencies and institutions in Nebraska and handles any complaints related to professional licenses or certifications. Once the grievance/complaint has been resolved, the DDD Director or designee will provide a written notification of the outcome to the complainant. Resolution of the grievance/complaint may involve working with DHHS Division partners, multiple providers, and/or the participant's ISP team, thus, there is no specified timeframe for the state making resolution and notifying the complainant. Designated DDD and/or DPH staff are expected to take immediate steps to make resolution and notification. Documentation of the issue and outcome will be retained by DDD in an electronic complaint log maintained by DDD. All grievances/complaints are maintained in electronic form, in accordance with the Records Retention Schedule applicable to the Division of Developmental Disabilities(DDD). Given that the log is maintained electronically, there is no time limit for maintaining the log.

c) The mechanisms that are used to resolve grievances/complaints.

The mechanisms for resolving the complaint and preparing the response include, but are not limited to, follow-up by phone, letter, home visit, provider agency visit, DPH licensing, and/or referral to another agency (e.g., Child Welfare Services, Adult Protective Services and Medicaid Fraud Control Unit).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Division of Developmental Disabilities (DDD) defines incidents as allegations or occurrences of abuse, neglect, and exploitation; events that cause harm to a participant; and events that serve as indicators of risk to participant health and welfare.

The following definitions apply to adults age 18 and older:

Abuse is defined as 1) the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or personal anguish; or 2) any knowing or intentional act which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, or sexual exploitation.

Exploitation means the taking of property of a vulnerable adult by any person by means of undue influence, breach of a fiduciary relationship, deception, or extortion or by any unlawful means.

Neglect is defined as;
(1) Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Staff failure to intervene appropriately to prevent self-injurious behavior may constitute neglect. Staff failure to implement facility safeguards, once client to client aggression is identified, may also constitute neglect; OR
(2) Any knowing or intentional act or omission on the part of a caregiver to provide essential services, or the failure of a vulnerable adult, due to physical or mental impairments, to perform self-care or obtain essential services to such an extent that there is actual physical injury to a vulnerable adult or imminent danger of the vulnerable adult suffering physical injury or death.

Physical injury means damage to bodily tissue caused by nontherapeutic conduct, including, but not limited to, fractures, bruises, lacerations, internal injuries, or dislocations, and shall include, but not be limited to, physical pain, illness, or impairment of physical function.

The following definitions apply to child maltreatment which occurs when a child age birth through age 17 is physically, emotionally, or sexually harmed.

Abuse can be physical, emotional or sexual and is defined as:
Physical: Information indicates the existence of an injury that is unexplained; not consistent with the explanation given or is non-accidental. The information may also only indicate a substantial risk of bodily injury.
Emotional: Information indicates psychopathological or disturbed behavior in a child who is documented by a psychiatrist, psychologist or licensed mental health practitioner to be the result of continual scapegoating, rejection or exposure to violence by the child's parent/caretaker.
Sexual: Information indicates any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

Neglect can be emotional or physical and is defined as:
Emotional: Information indicates that the child is suffering or has suffered severe negative emotional effects due to a parent's failure to provide opportunities for normal experience that produce feelings of being loved, wanted, secure and worthy. Lack of such opportunities may impair the child's ability to form healthy relationships with others.
Physical: Information indicates the failure of the parent to provide basic needs or a safe and sanitary living environment for the child. Parent includes guardian, custodian and caretaker.

Medical Neglect of Handicapped Infant: The withholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from disabled infants with life-threatening conditions. Exceptions include those situations in which:
(1) The infant is chronically and irreversibly comatose;
(2) The provision of this treatment would merely prolong dying or not be effective in ameliorating or correcting all the infant's life-threatening conditions; or
(3) The provision of this treatment and the treatment itself under these conditions would be inhumane.

Any reason to believe that abuse and/or neglect has occurred is reportable under Nebraska state statutes to the Department of Health and Human Services (DHHS) Protection and Safety unit (housed at the Division of Children and Family Services) or law enforcement. There is no statute of limitations on reporting abuse and/or neglect. Reports can be taken by DHHS at a toll free abuse and neglect hotline that is available 24/7 and posted on the DHHS website. Reports are also accepted by e-mail, FAX, letter or face-to-face at any DHHS office.

Nebraska Revised Statute 28-372 mandates the following entities to report suspected abuse, neglect, or exploitation of a vulnerable adult: "any physician, psychologist, physician assistant, nurse, nursing assistant, other medical, developmental disability, or mental health professional, law enforcement personnel, caregiver or employee of a caregiver, operator or employee of a sheltered workshop, owner, operator, or employee of any facility licensed by the DHHS Division of Public Health (DPH), or human services professional or paraprofessional not including a member of the clergy." Nebraska Revised Statute 28-711 requires all persons to report suspected child abuse or neglect.

In addition, under state policies, a provider must document in the Department approved web-based electronic records system any allegation of abuse or neglect as soon as possible but at a minimum within 24 hours of the provider becoming aware of the incident. A DHHS supervisor is notified electronically when an allegation of abuse and/or neglect is entered into the system.

1. Allegation of abuse and/or neglect.
2. Allegation of financial exploitation.
3. Allegation of sexual exploitation.
4. Injuries to participants which require medical attention and treatment by physician.
5. Injuries to participants related to incidents involving physical restraint.
6. Discovery of injury of unknown origin.
7. Injuries or displacement of participant as a result of fire.
8. Medication error resulting in injury, serious illness, or hospitalization.
9. Use of physical restraint
10. Use of prohibited practices such as chemical or mechanical restraint for any reason.
11. Injuries which require medical attention to staff persons and others, resulting from the behavior of a participant.
12. A participant served leaving supervision where the safety of the participant or others is potentially threatened.
13. Use of an emergency room or an urgent care facility for treatment or admission.
14. Possible criminal activity by a participant or by a staff person suspected of engaging in criminal activity towards a participant.
15. Missing person.
16. Property damage caused by participant or staff person.
17. Seizure that last over five minutes or over the timeframe set by the participant's physician, or which requires treatment at an urgent care center, ER or hospital.
18. Deaths of participants served.
19. Hospitalization.
20. Law enforcement contacts (i.e. visits to assess or control situations) due to the behavior of a participant served.

A written summary of the provider's investigation and action taken must be submitted via the electronic records system to the Department within 14 days of the electronic report of the incident.

Should DDD have significant concerns about any provider's performance in managing critical events or incidents, DDD reserves the right to request from any provider an ongoing aggregate report of incidents that may include, but not be limited to, a compilation, analysis, and interpretation of data, and evidentiary examples in order for DDD to evaluate performance and monitor the provider's ability to demonstrate a reduction in the number of incidents over time.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from abuse, neglect, and exploitation is annually provided to each participant and their legal representative by their Service Coordinator, and is also available on the DDD website. There is also a training available to the general public, including participants, family members and providers on the DDD website.

Service Coordination must review and provide a copy of participant rights and the appeal process at the intake meeting and annually thereafter. As applicable, these materials are translated and provided in Spanish. In addition, DDD complies with the LEP Language Assistance Implementation Guidance as per Presidential Executive Order 13166.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Upon receipt of a report, the geographically assigned DDD Service Coordinator Supervisor reviews it to determine the appropriate response, which depends upon the type and frequency of the incident. All reports involving health and safety concerns require follow-up actions from the service coordinator. Incidents with law enforcement activity are followed-up to ensure the participant/legal representatives are aware of the natural and logical consequences of the participant's actions if competent. If the participant is not deemed competent then ensuring appropriate supports are in place to ensure safety. When providers report alleged abuse and neglect of adult participants that is not required to be reported by law, Protection and Safety staff shares this information with DDD within 24 hours of receipt. The DDD geographically assigned DDD Service Coordinator Supervisor reviews it with the assigned service coordinator to determine if the participant is safe, and completes an emergency safety plan as needed.

DHHS Protection and Safety staff sends a copy of the intake investigation of reportable allegations of neglect or abuse to DDD.

Timeframes for conducting, completing, and informing the participant of the results of an investigation completed internally by the DD provider are determined by the DD provider agency and are outlined in the DD provider's policies and procedures but are completed in a minimum of 30 calendar days. Timeframes for state staff are established within the program, following statutory and regulatory mandates when required. Timeframes vary depending upon the involvement of law enforcement and the nature of the critical event.

The Division of Children and Family Services Protection and Safety Unit handles all reports of abuse and/or neglect and/or exploitation, which are screened immediately and shared with law enforcement within 24 hours of receipt. Only accepted reports are prioritized for a response.

Reporters are provided with a disposition on whether a report will be accepted and assigned to DCFS for investigation OR there is no indication that the alleged victim is a vulnerable adult or the allegations do not rise to the level of maltreatment and the matter will not be assigned for investigation. In certain situations a hotline worker may have to inform the reporter that further consultation needs to occur with a supervisor and a call back number may be requested so hotline can call the reporter back to inform them of the screening decision. Reports of abuse and neglect are reviewed by a trained Children and Family Services (CFS) Intake Specialist and a CFS Supervisor. CFS Intake Specialists utilize the Structured Decision Making (SDM) Intake Tool, history from database exchange systems and the information provided in the alleged report of abuse and neglect to determine if Adult Protective Services (APS) has the authority to intervene. The SDM Intake tool is a research based instrument that outlines specific criteria that the CFS Intake Specialist must consider in determining whether the allegations meet the criteria for APS involvement and subsequently the appropriate response time. There are specific definitions that need to be met in order to determine whether a report will be accepted for investigation. The CFS Intake Specialist must use the definition of a vulnerable adult, and the definitions of abuse, neglect and exploitation that are defined in Nebraska State Statute and APS regulations as part of determining whether APS should intervene.

Adult Protective Services:
Investigations of allegations of abuse and/or neglect and/or exploitation of vulnerable adults are performed by adult protective services (APS) staff in the Division of Children and Family Services and are categorized in three priorities. As outlined in the Adult Protective Services Act, see Nebraska Revised Statutes 28-350 to 28-371.

APS staff conducts screenings of abuse and/or neglect and/or exploitation and if the report is accepted for investigation, the reports are prioritized as follows:

A Priority 1 report of allegation of immediate danger of death or life-threatening or critical harm to a vulnerable adult participant, including death or other vulnerable participants still at risk has a 60-day time frame in which to complete an investigation. Face-to-face contact must be made with the victim as quickly as possible, but no later than within 8 hours. If APS staff cannot make immediate contact with the alleged victim, law enforcement must be contacted to request that they conduct an investigation and send a written summary of their investigation to the Protection and Safety worker. APS staff may work simultaneously with law enforcement if requested.

A Priority 2 report of an allegation of danger of serious, but not life-threatening or critical, harm to a vulnerable adult participant has 60 days in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 5 calendar days of the date of the report was accepted for investigation.

A Priority 3 report alleges harm to a vulnerable adult participant which is serious, but not serious enough to be considered Priority 1 or 2 and has 60 days in which to complete an investigation. Face-to-face contact by APS staff or law enforcement must be made with the victim within 10 calendar days of the date of the report was accepted for investigation. APS would not accept an investigation when the information reported to the CFS Intake Specialist at the Adult Abuse and Neglect Hotline and researching collateral information (i.e., criminal databases; history of APS; previous law enforcement involvement; contacting medical professionals; etc.) does not provide sufficient information to determine that the allegation rises to the level of abuse or neglect.

Child Protective Services:
Investigations of allegations of abuse and/or neglect of children are performed by child protective services (CPS) staff in the Division of Children and Family Services. Since both law enforcement agencies and CPS have statutory obligations pertaining to child abuse/neglect cases, it is necessary to establish which agency will take the primary responsibility for a given case and which kinds of cases will initially be a joint effort. The suggestions below do not preclude joint investigations or an independent assessment by the Department.
Cases appropriate for joint activities may include but not be limited to:
• Sexual assault or abuse of a child by a household member;
• Abuse/neglect in child care homes, child care centers or institutions; and
• Abuse/neglect in foster homes or allegations of abuse/neglect committed by foster parents or foster care providers.
• Cases for law enforcement conducting primary investigation activities depend on established local protocols and may include:
• Severe physical abuse;
• Neglect, such as lack of food, unsanitary or dangerous living conditions and lack of essential utilities;
• Children being left unattended or lack of supervision;
• Chronic or extreme spouse abuse in the child's presence; and
• When criminal activity is involved.

At initial assessment, the primary roles of CPS are to gather information to validate maltreatment or allegations on a court petition and to determine what services, if any, are needed and how they can best be provided. When necessary, a plan will be developed and implemented to provide safety for the child. The priority at this phase is securing child safety with attention to working with the family to preserve the family unit whenever possible.

CPS uses an Assessment tool, initial assessment sections, and the case status determination, the worker can then determine the Department response. Six alternatives are available to the worker and family following case status determination:

1. Worker determines no further intervention service is needed. Case is closed following notification to the family.
2. Worker determines there is a need for further service that can be provided through a community agency or other Department service program. The family is willing to voluntarily engage in the service. The case is closed following engagement of family in the service.
3. Worker determines that ongoing protective services are required to address or control the maltreatment and risk identified in the initial assessment. The family is willing to voluntarily engage in CPS service provision. Case is transferred to the ongoing services for service continuation, further assessment and case planning. (These cases are referred to as "voluntary" cases.)
4. Worker determines that ongoing protective services are required to resolve or control the maltreatment and risk identified in the initial assessment. The family is unwilling to voluntarily engage in services identified as necessary. In these instances, the worker is required to formally request that the county attorney file a petition for court authorization to intervene. (See Court & Legal Issues, 390 NAC 8-000) When court authority is granted, the case is transferred for ongoing services, further assessment and case planning. (These cases are referred to as "involuntary cases".)
5. Worker determines that ongoing services are needed; the family is willing to engage in the services identified as necessary, but court involvement is needed to resolve the identified problem, for example, incest cases.
6. Worker determines a need for ongoing protective services; the parents are unwilling to cooperate, and the county attorney has determined there is inadequate factual information to pursue court action. Case is closed following notification to the family.

The State's regulations identify the relevant parties that may request the results of the investigation and these regulations are on the public website at: http://dhhs.ne.gov/children_family_services/Pages/jus_jusindex.aspx. There is no specified timeframe for release of the information after the completion of an investigation regardless of priority as release of said information is done only upon request. The participant or their representative are informed of the release of information contained in the registry upon request at the time of the investigation by the investigator. There is no mandate nor formal timeline for releasing information to the participant or their representative as this is only done upon their written request. The request can be made at any time, but the response will not occur until the conclusion of the investigation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Developmental Disabilities within DHHS, the State Medicaid agency, is responsible for overseeing the reporting of, and response to, critical incidents and events.
All critical events are entered into a web-based electronic records system and are subject to DDD analysis at any time but no less frequently than quarterly. This information includes a compilation, analysis, interpretation of data, and evidentiary examples to evaluate performance. The DDD Director reserves the right to request additional review of any incident brought to her attention as a result of the oversight process. There may be immediate follow-up of individual events.

Adult and Child Protection and Safety staff are contained within the Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services. Protection and Safety staff are also responsible for the oversight of the critical incident management system.

On at least an annual basis, both Adult and Child Protection and Safety staff provide to DDD information about critical incidents that involved waiver participants. Data is obtained and analyzed on waiver participants involved in Protection and Safety reports. The data includes demographic information, types of abuse/neglect reported, and the findings of investigations.

Staff from Protection and Safety and DDD collaborate to identify strategies to reduce the occurrence of critical incidents and to coordinate better on both a system wide and individual participant basis. Examples of these strategies include training of staff from Protection and Safety about this waiver, and cross training to Services Coordinators about Protection and Safety.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In Nebraska, restraint means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal function of a portion of the participant's body, or to control the behavior of a participant. Nebraska does not make a distinction between restrictive interventions and restraints, and all policies under G2a apply to restrictive interventions as well.

Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are not to be considered as a restraint such as side rails while transporting a patient to a surgical suite.

Physical restraint can be used in a situation where the participant is in danger of immediate jeopardy or harm. If there are disruptive or challenging behaviors displayed by a participant, then a safety and support plan must be developed utilizing the principles of positive behavioral supports. Restraint may not be used as punishment; for the convenience of staff; or as a substitute for habilitation. Restraint is allowable as an immediate response when it is planned in advance and documented in the behavioral support plan. Restraint cannot be used as a way to deal with under-staffing or as a way to deal with ineffective, inappropriate, or other nonfunctional programs or environments. Corporal punishment, verbal abuse, physical abuse, psychological abuse, denial of an adequate diet, use of a participant to discipline another participant, and placement of a participant in a totally enclosed crib or other barred enclosure are prohibited.

Mandates regarding the use of restraint are detailed in Title 404 of the Nebraska state regulations and must be included in provider policies, procedures, and practices. Specifically, the regulation states that the provider must prohibit the use of restraints except as noted above.

Physical restraint is allowable as an immediate response to an emergency safety situation as a component of a behavioral support plan developed in response to an emergency safety situation. The safety plan is instituted in instances where the participant poses a threat to themselves, others or property and must be kept from harm.

The requirement for behavioral support plans act as a safeguard in the use of restraints because each plan must detail the restraints that may be used for the participant. They also reduce the use of restraints by providing information about common behaviors for the participant. Behavioral support plans must address behaviors that are obstacles to becoming more independent; that interfere with the ability to take part in habilitation; self-injurious behaviors; or behaviors that are a threat to others. The provider's policies and procedures must specify and define approved intervention procedures, and include a description of the mechanism for monitoring the use. The following components must be in place in a behavioral support plan, a safety plan, and in order to develop emergency safety interventions specific to each participant:
1. The functional assessments that defines the communicative function of the behavior for the participant and what purpose the behavior serves in the participant's life as well as a review of the participant's day and residential supports and other relevant data;
2. A safety plan for the participant that emphasizes positive meaningful activities, individualized support, and options that are incompatible with the behavior targeted for change. The plan must include a description of potential stressors and triggers that may lead to the participant experiencing a crisis, and describe a comprehensive safety program. The participant's safety plan must include the type of physical restraint, the length of time the emergency intervention will be utilized in each instance, and the monitoring procedures that the staff will perform during each instance. There must be meaningful and individualized data collection and data analysis that tracks progress. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.
3. Prior written consent of the participant or the legal representative must be obtained before implementing the behavioral support plan.

The provider must establish a Review Committee to provide prior review and approval of all behavior support plans, including those that utilize restraints. The effectiveness of the intervention in conjunction with the behavior support plan must be monitored and reviewed. The monitoring of the effectiveness of the intervention is completed on an ongoing basis by designated provider staff that are responsible for quality assurance activities. The Review Committee must have persons qualified to evaluate behavior support plans and a physician, pharmacist, or other allied health professional qualified to evaluate proposals that include the use of medications specifically targeted for behavioral change. The monitoring of the effectiveness of the intervention is completed on an ongoing basis by designated provider staff that are responsible for quality assurance activities.

Direct support and other staff are informed of potential side effects in the event of chemical restraint, in non-technical terms, in DDD's electronic health records system so participants can be monitored for early detection of side effects. The provider must make reports to the physician based on this review.

Medications must be documented in the service plan with the name, dosage, reason for, and the specific behaviors to be affected by the medication; whether the use of the drug was reviewed by the agency's review committee; and whether the drug is reviewed on an ongoing basis by a physician. Medication to manage behavior must be used only in dosages that do not interfere with the participant's ability to take part in habilitation and daily living activities. The use of medication is documented after each drug administration. Medications used solely for the purpose of supporting mental illness may be used only with the consent of the participant or legal representative and medications should never be utilized in the absence of other behavioral measures to address the frequency and intensity of target behaviors.

The service plan must include that a less restrictive and less intrusive method had been tried and systematically applied and determined to be ineffective before implementation of psychotropic medications or emergency safety interventions such as physical restraints or seclusion for the purpose of modifying behavior. The team must evaluate and document that harmful effects of the behavior clearly outweigh any potential harmful effects of the use of restraints or seclusion.

A participant may receive PRN psychotropic medications as prescribed by a licensed clinical medical practitioner functioning within their scope of practice. The following parameters are in place to ensure the appropriate use of PRN psychotropic medications:
• In general, all PRN medicines should only be prescribed based on participant clinical need and not prescribed in advance of anticipated need for controlling behavior not linked to clinical need, or routinely upon admission into a residential provider program.
• Provider staff must be trained in alternative ways of dealing with participant agitation. Those less restrictive methods must be utilized and proven ineffective as determined by the licensed clinical medical practitioner functioning within their scope of practice.
• PRN medications cannot be utilized in advance or routinely on admission.
• Antipsychotic PRN should only be used for agitation due to acute symptoms of a mental illness.
• All PRN medicines should be prescribed with documentation indicating awareness of regular or standing psychotropic medications/dosages and indicate whether the PRN dosage constitute high dose prescribing outside of standard clinical recommendations.
• Staff administering PRN medication should be aware of its potential to raise the total daily dose above the British National Formulary (BNF) maximum licensed dose.
• Intramuscular (IM) and oral doses will be entered into THERAP separately as maximum daily dose for each route is different
• Medication Administration Records (MAR) State frequency, maximum dose and indication clearly.
• If it is clinically appropriate for the dose to be prescribed as a range, the lowest strength should be offered first.
• All PRN prescriptions should be reviewed at least once a week by the team.
• Participants prescribed PRN high dose antipsychotics must be regularly reviewed (at least once a week) and the high dose antipsychotic only continued for the shortest time necessary.
• All PRN medication which is administered should be clearly documented by staff in the participants MAR.
• When PRN antipsychotics are added the participants must be monitored for response to treatment, including adverse reactions, side effects and physical health.
• Obtain a current consent to treatment paperwork that addresses whether or not PRN usage of psychotropic medication has been ordered for the individual and specifies the clients consent for PRN usage when such an order is in place.
• A medication administration record summary (the last 30 days) will be provided to any treating clinician when a medical or psychiatric appointment occurs.

Prior to implementation of restraints or restrictive interventions, employees must complete training and competency standards established by the provider in the following areas:

• Dignity and respectful interactions with participants;
• Abuse, neglect, and exploitation, and state law reporting requirements and prevention;
• Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the individual;
• Participants' safety protocols as applicable;
• Positive support techniques; and
• Approved emergency safety intervention techniques that include physical restraints and/or seclusion.

DD provider staff that administer medication must meet the competency standards defined in Title 172, Chapter 95, Regulations Governing the Provision of Medications by Medication Aides and other Unlicensed Persons. The competency standards are listed in Appendix G-3-C-ii.

The methods for detecting the unauthorized use, over use or inappropriate and/or ineffective use of emergency physical restraints or seclusion, and behavior modifying drugs, and ensuring that all applicable state requirements are performed by state staff are as follows:
• On-site certification review activities;
• Review of critical incident reports;
• DDD Service Coordination monitoring; and
• Complaint investigations.

See Appendix G-2-a-ii for additional information.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHHS DDD is responsible for overseeing the use of restraints and ensuring that the state's safeguards are followed.

The methods for detecting the unauthorized use, over use or inappropriate and/or ineffective use of emergency physical restraints or seclusion, and behavior modifying drugs, and ensuring that all applicable state requirements are performed by state staff are as follows:
• On-site certification review activities;
• Review of critical incident reports;
• DDD Service Coordination monitoring; and
• Complaint investigations.

On-Site Certification Review. The provider's policies and procedures must be based on state regulations applicable to the use of medications or emergency safety interventions of physical restraint or seclusion.

Oversight is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-I for additional information.

Information regarding the provider's capacity to support participants with behavioral challenges is gathered during the initial provider enrollment activity. Detection of unauthorized use of restraints may also occur at the time of provider enrollment. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of restraints and seclusion in emergency safety situations. The provider must have an internal quality review system and a Review Committee. When DDD program staff find policies and procedures that do not comply with regulatory requirements, such as unallowable intervention techniques, an insufficient QI system, an inadequate Review Committee, etc., the provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD prior to providing services to participants.

Following enrollment, DDD central office analyzes the length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered. When a provider has difficulty developing their policies and procedures related to the use of restraints, DDD works with Department of Public Health (DPH) surveyors to ensure that certification reviews include a focus on those issues and have a greater number in the sample of waiver participants who have behavioral support plans.

A summary of certification activities is completed by DPH and is reviewed semi-annually by the Quality Improvement Committee. The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits, or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

Detection of unauthorized use of restraints may occur through on-site certification review activities, which may be unannounced or scheduled. During a scheduled certification review conducted by DDD, delivery of service is reviewed as well as the agency's systems. At least one participant included in the targeted sample must be taking medications which are used in support of a mental illness. At a minimum, 33% of the sample includes participants taking medications which are used in support of a mental illness. The sample is never of only one participant and always includes at least three. If additional participants included in the sample also take medications which are used in support of a mental illness, the reviewer will review all pertinent documentation for those participants as well. An entire checklist is devoted to review of the development, approval and review of the medication and how it is incorporated into a training program designed to lessen the need for the restrictive procedure.

Review of critical incidents. Reporting of incidents is another method to detect unauthorized use of restraints. Complaint investigations and investigations of allegations of abuse or neglect performed by DDD service coordination and Division of Public Health (DPH) surveyors may also reveal unauthorized, overuse, or inappropriate/ineffective use of restraints. Action that is taken by DDD and/or DPH, if it is determined through an investigation that unauthorized restraints/inappropriate interventions/unknown injuries are discovered, actions may include an unannounced on-site focused certification review with deficiencies cited, followed by a provider plan of correction and follow-up visits. Action may also include requiring the provider to seek training mandated by the State, placing the provider on probation, limiting admissions, or recoupment of payments made to the provider. Please refer to Section G-1 for an extensive description of DDD's management of critical incidents.

Incident reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance. The Quality Improvement Committee (QIC) reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types and numbers of incidents, including illegal use of restraints by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

Service Coordination monitoring. DDD Service Coordination monitoring may detect unauthorized use of restraints. Monitoring of 100 percent of all participants is designed to review the implementation of each participant's service plan after both the annual and semi-annual team meetings. In addition, the SC conducts ongoing unannounced monitoring, which allows for focused monitoring if issues have been raised or are noted during the time of a full monitoring. Observations are documented on a checklist and entered into the electronic health records system. If aggressive behaviors, rights restrictions, or injuries are observed, the service coordinator will question provider staff and review participant files, which may reveal unauthorized interventions, inappropriate interventions, or injuries of an unknown nature.

To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into a web-based database. This allows for individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, the SC Administrator, and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local service coordination level with reports being provided to the DDD central office staff on a quarterly basis.

Complaint investigations. A report of complaint investigations, which would include illegal use of restraints, is reviewed on a semi-annual basis by the DDD QI Committee. The report, prepared by DDD includes the number and type of complaints, as well as the disposition of the complaint.

The DDD QI committee also reviews semi-annual reports of activities performed by the Death Review Committee, which would include deaths caused by improper use of restraints.

Data analysis. The frequency of the oversight activities varies by activity. The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. Walk-through activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data. Data from these activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.

Data from the above activities are gathered and analyzed to identify state-wide trends and patterns and support improvement strategies. A summary of certification activities is completed by DPH staff and is reviewed semi-annually by the DDD QI Committee (QIC). The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. walk-throughs), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

Quarterly, the DDD Quality Improvement Committee reviews an aggregated report compiled from the statewide database of critical incidents and events, including restraint utilization. This also includes aggregated DDD Service Coordination monitoring reports.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Permitted restrictive interventions (referred to in Nebraska as "restraints") include an action or procedure that limits a participant's movement; a participant's access to other participants, locations or activities; or restricts participant rights. The use of restraints are not allowable habilitation techniques unless incorporated into an approved behavior support plan when the participant must be kept from harm (e.g., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the participant).

Protocols for the use of restraints are written into state regulations and must be included in provider policies, procedures, and practices.

The following documentation is required when restraints are used:
• Written agency provider policies and procedures;
• Written positive support plan to be used in conjunction with the restraint, the criterion for the elimination of the restraint, and method to collect data;
• Written discussion and prior approval by the service plan team and documentation the service plan team's determination of the participant's ability to acquire, retain, or understand the information proposed in the restraint;
• Written informed consent;
• Incident reports related to the use of restraints; and
• Orientation, training, and/or competency standards for staff prior to implementation of restraints.

Every time a provider utilizes a restraint they are required per the General Event Report (GER) guide to complete a High GER into DDD's electronic records system.

The provider must develop a policy specifying whether they allow for the use of restraints. If the provider allows the use of restraints, the written policies and procedures must include the following:
• The restraint determined necessary for one participant must not affect other participants who receive services in that setting;
• The restraint must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation, or as a behavior support plan;
• The restraint must be the least restrictive and intrusive possible;
• All restraints must be temporary;
• Prior to proposing a restraint, there must be documented evidence that other less restrictive methods had been regularly applied by trained staff and failed;
• The restraint must be safe for the participant; and
• Provider-approved restraints must be specified and defined.

Restraints can only be used as an integral part of a written habilitation strategy that is designed to lead to a less restrictive way of addressing the unacceptable behavior and ultimately to the elimination of the behavior for which the restrictive measure is used.

The provider must ensure that the written habilitative strategies stress positive approaches in addressing behaviors. The provider must have written policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each participant.

The safeguards for detecting the unauthorized use of restraints include provider enrollment, on-site certification reviews, reporting of incidents, service coordination monitoring, and investigation of complaints, practices, protocols, and documentation for the use of restraints, including medications used to support a mental illness, and the use of restraint or seclusion. See G-2-a-i and G-2-a-ii for additional information.

Prior to implementation of a restraint, the provider must ensure review and written approval by the service plan team and rights review committee and written informed consent.

The provider must participate in the service plan team process to discuss and review the proposed restraint prior to implementation. The service plan must document the service plan team's determination of the participant's ability to acquire, retain, or understand the information proposed in the restraint. The discussion and approval of the use of the restraint including the following must be recorded in the participant's service plan:

• The proposed restraint(s);
• Methods previously tried and shown to be ineffective;
• Risks involved with the restraint and risk involved if no restraint is used;
• Rationale for the proposed restraint;
• Other possible alternative methods;
• Strategies to lead to elimination of the restrictive measure and the criterion for the elimination of the restraint; and
• Frequency that the participant's service plan team will review the effectiveness of the plan, but not less than every six months. The service plan team review must address: the original reason for restraint, current circumstances, success or failure of the positive behavior support plan, and the rationale based on evidence for continued use of the restraint; and decrease in the use or elimination of the restraint as soon as circumstances justify, based on established and approved criterion in the service plan.

The provider must obtain written informed consent from each participant, or guardian or legal representative as applicable, for authorization to use a restraint. The written informed consent or emergency verbal consent must be obtained prior to implementation of the restriction.

In addressing maladaptive behavior, the provider must develop and implement policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each participant. The provider must ensure the following behavior supports and emergency safety interventions for emergency safety situations:

The provider must assure that the following components of positive behavioral supports are in place:
• The assessment must define the communicative function of the behavior for the participant;
• The assessment must focus on what purpose the identified behavior serves in the participant's life;
• A review of the participant's day supports, residential supports, and other relevant data must be incorporated in the assessment process;
• A behavior support plan for the participant must be developed that emphasizes positive meaningful activities and options that are incompatible with the behavior targeted for change;
• There must be a combination of a planned meaningful day and individualized supports for the participant;
• The plan must include a description of potential stressors and triggers that may lead to the participant experiencing a crisis. Once identified, there must be a comprehensive safety program developed and implemented; and
• There must be meaningful and individualized data collection and data analysis that track the progress of the participant. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.

If restraint is utilized, prior written consent of the participant or the legal representative must be obtained, except in emergency situations.

Incidents related to the use of restraint must be documented and reported. Please refer to Section G-1 for a description of DDD's critical incident reporting system.

The provider must ensure that employees responsible for providing supports and services to participants are educated and trained on the minimum requirements necessary to address the participant's needs prior to working with participants in services.

Staff responsible for providing direct services must demonstrate the competence to support participants as part of a required and on-going training program. The provider must ensure staff

receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with participants.

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated via competency-based testing. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas.

Initial orientation must be completed by all new employees prior to working alone with participants. Employees must complete the following training requirements:
Participant's choice;
• Participant's rights in accordance with state and federal laws;
• Confidentiality;
• Dignity and respectful interactions with participants; and
• Abuse, neglect, and exploitation and state law reporting requirements and prevention.

Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 days of hire or before working alone with a participant. The following training areas must be addressed:
• Emergency procedures;
• Cardiopulmonary resuscitation;
• Basic first aid;
• Infection control;
• Participants' medical protocols as applicable; and
• Participants' safety protocols as applicable.

Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to participants. This training must include:
• Implementation and development of the service plan and interdisciplinary process;
• Positive behavior support techniques;
• Approved restraint techniques;
• Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the participant;
• Use of adaptive and augmentative devices used to support participants, as necessary;
• Other training required by the provider; and
• Other training as required by the specific service options.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHHS Division of Public Health (DPH) staff and surveyors are responsible for monitoring and overseeing the use of restraints.

The State performs methods for detecting the unauthorized use, over use or inappropriate/ineffective use of restraints and ensuring that all applicable state requirements are followed. The State-wide oversight responsibilities that are employed are the same as methods described in Appendix G-2-a-i, G-2-a-ii, and G-2-b-i.

DDD has recently become a National Core Indicators state and trend analysis data will also be gleaned from this source during the lifespan of the waiver.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Protocols for the use of seclusion as an emergency safety intervention are written into state regulations and must be included in provider policies, procedures, and practices. In emergency instances where the participant must be kept from imminent harm to self or other, the provider must use their reasonable and best judgment to intervene to keep the participant from injuring themselves or others. This may include the use of seclusion - hands-on guidance away from harm or to another area or room to safely protect the participants and others from immediate jeopardy or physical harm. A participant could be physically guided away from an area and staff may block the exit. The participant would always have line-of-sight supervision, and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The participant could not be put in a room with the door closed and no one watching them. Seclusion from harmful circumstances or from participants at risk can only be used as an emergency safety intervention when the participant must be kept from imminent danger to self or others (e.g., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the participant) and must be reported immediately on the DDD electronic records system.

The following documentation is required when seclusion is used as an emergency safety intervention:
• Written agency provider policies and procedures;
• Written positive support plan to be used in conjunction with seclusion;
• Written discussion and prior approval by the service plan team and documentation of the service plan team;
• Written informed consent;
• Incident reports related to the use of seclusion; and
• Orientation, training, and/or competency standards for staff prior to implementation of restraints.

Every time a provider utilizes a restraint they are required per the General Event Report (GER) guide to complete a High GER into DDD's electronic records system.

The provider must develop a policy specifying whether they allow for the use of seclusion as an emergency safety intervention. If the provider allows the use of seclusion, the written policies and procedures must include the following:
• The seclusion of one participant must not affect other participants who receive services in that setting;
• The seclusion must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation, or as a behavior support plan;
• Seclusion as an emergency safety intervention must be the least restrictive and intrusive possible;
• Seclusion must be temporary;
• The seclusion must be safe for the participant; and
• Methods of seclusion must be specified and defined.

The safeguards for detecting the unauthorized use of seclusion include provider enrollment, on-site certification reviews, reporting of incidents, service coordination monitoring, and investigation of complaints, practices, protocols, and documentation for the use of seclusion. See G-2-a-i and G-2-a-ii for additional information.

The provider must participate in the service plan team process to discuss and review the use of seclusion prior to implementation. The service plan must document the service plan team's determination of the participant's ability to acquire, retain, or understand the use of seclusion. The participant's service plan team will review the effectiveness of the use of seclusion, but not less than every six months. The service plan team review must address: the original reason for the use of seclusion, current circumstances, success or failure of the positive behavior support plan, and the rationale based on evidence for continued use of seclusion; and decrease in the use or elimination of seclusion as soon as circumstances justify, based on established and approved criterion in the service plan.

The provider must obtain written informed consent from each participant, or guardian or legal representative as applicable, for authorization to use seclusion. The written informed consent or emergency verbal consent must be obtained prior to implementation of seclusion as an emergency safety intervention.

The provider must assure that the following components of positive behavioral supports are in place:
• The assessment must define the communicative function of the behavior for the participant;
• The assessment must focus on what purpose the identified behavior serves in the participant's life;
• A review of the participant's day supports, residential supports, and other relevant data must be incorporated in the assessment process;
• A behavior support plan for the participant must be developed that emphasizes positive meaningful activities and options that are incompatible with the behavior targeted for change;
• There must be a combination of a planned meaningful day and individualized supports for the participant;
• The plan must include a description of potential stressors and triggers that may lead to the participant experiencing a crisis. Once identified, there must be a comprehensive safety program developed and implemented; and
• There must be meaningful and individualized data collection and data analysis that track the progress of the participant. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.

If seclusion is utilized, prior written consent of the participant or the legal representative must be obtained, except in emergency situations.

Incidents related to the use of seclusion must be documented and reported. Please refer to Section G-1 for a description of DDD's critical incident reporting system.

The provider must ensure that employees responsible for providing supports and services to participants are educated and trained on the minimum requirements necessary to address the participant's needs prior to working with participants in services.

Staff responsible for providing direct services must demonstrate the competence to support participants as part of a required and on-going training program. The provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with participants.

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated via competency-based testing. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas.

Initial orientation must be completed by all new employees prior to working alone with participants. Employees must complete the following training requirements:
Participant's choice;
• Participant's rights in accordance with state and federal laws;
• Confidentiality;
• Dignity and respectful interactions with participants; and
• Abuse, neglect, and exploitation and state law reporting requirements and prevention.

Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 days of hire or before working alone with a participant. The following training areas must be addressed:
• Emergency procedures;
• Cardiopulmonary resuscitation;
• Basic first aid;
• Infection control;
• Participants' medical protocols as applicable; and
• Participants' safety protocols as applicable.

Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to participants. This training must include:
• Implementation and development of the service plan and interdisciplinary process;
• Positive behavior support techniques;
• Approved emergency safety intervention techniques;
• Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the participant;
• Use of adaptive and augmentative devices used to support participants, as necessary;
• Other training required by the provider; and
• Other training as required by the specific service options.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHHS DDD is responsible for overseeing the use of seclusion and ensuring that the state's safeguards are followed.

The methods for detecting the unauthorized use, over use, or inappropriate and/or ineffective use of seclusion as an emergency safety intervention, and ensuring that all applicable state requirements are performed by state staff are as follows:
• On-site certification review activities;
• Review of critical incident reports;
• DDD Service Coordination monitoring; and
• Complaint investigations.

The State-wide oversight responsibilities that are employed are the same as methods described in Appendix G-2-a-i, G-2-a-ii, and G-2-b-i.

DDD has recently become a National Core Indicators state and trend analysis data will also be gleaned from this source during the lifespan of the waiver.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96). Medication Administration Records (MARs) are housed in DDD's electronic health record system, which all providers have access to; providers are mandated to update MARs in this system effective January 1, 2017. Prior to January 1, 2017 providers utilize other electronic information or paper systems to monitor medication administration. Compliance reviews of the provider are completed by the Division of Public Health within DHHS.

First line responsibility for monitoring participant medication regimens resides with the medical professionals that prescribe the medications, every time that the professional prescribes the medications. The medical professional that prescribes the medications determines the frequency of the monitoring, based on the participant's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues.

Medications used solely for the purpose of support of a mental illness may be used only with the consent of the participant or legal representative.

The monitoring of the appropriateness of each medication and the appropriateness of multiple medications is the responsibility of the medical professionals who prescribe them and the pharmacist who fills the prescriptions.

First line monitoring methods are carried out by the DD provider, and consist of documenting and reporting the following to the physician at every appointment, legal representative when requested, and the delegating licensed health care professional: Unsafe conditions of medications; adverse reactions to medications; medication errors; and staff observations regarding the

behavior which the medication has been prescribed to reduce.

The second line monitors are licensed health care professionals whose scope of practice allows delegation of medication administration. The health care professionals, usually Registered Nurses, delegate the administration of medication to medication aides. The licensed health care professionals are employees of the DD provider agency or who have entered into a contract with the DD provider.
Second line monitoring activities and frequency of monitoring is determined by the health care professional and the DD provider. The medical professional that prescribes the medications determines the frequency of the health professional's monitoring which may be monthly, quarterly, semi-annually, or annually and is based on the participant's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues. The DD provider's monitoring activities may include observation of the administration of medications or treatment; review of records relating to medication provision or treatment; review of incident reports related to medication or treatment errors; retraining; and continued observations.

Staff observations regarding the behavior which the medication has been prescribed to reduce are also reported to the provider's review committee when the positive behavioral supports plan for that participant is scheduled for review. Each DD provider must have policies and procedures that identify the frequency of monitoring.

In addition to meeting statutory and regulatory requirements, the DD provider agencies must have policies and procedures addressing the provision of medications, per applicable state regulations.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement that includes frequency of QA/QI monitoring activities. The provider QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action. The provider's reports of QA/QI activities are reviewed on-site when DPH completes a certification review, annually or every two years, based on the certification status of the provider.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DHHS Division of Public Health (DPH) is responsible for the oversight of compliance with the Neb. Rev. § 71-6718 - 71-6743, known as the Medication Aide Act. The administration of medication is a regulated activity as a method to ensure that participant medications are managed appropriately. The purpose of the Medication Aide Act is to ensure the health, safety and welfare of participants through accurate, cost-effective, and safe utilization of medication aides for the administration of medications. Medication aides and other unlicensed persons may help with the physical act and documentation of provision of medication; and, under specific conditions such persons may also assist with monitoring therapeutic effects. Medication aides must be recertified every two years.

The administration of medication by licensed health care professionals is regulated by their respective practice acts. Under these regulations, administration of medication in the home is regulated only if provided through a licensed home health agency or through certified home and community-based providers. These regulations do not govern self-administration of medication. These regulations do not govern the provision of medication in an emergency situation. Licensed home health agencies do not administer medications to waiver participants that receive provider operated waiver services. This section only applies to medications administered by certified DD agency providers.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:
1. Review of each DD provider's policies and procedures during the provider initial certification process;
2. On-site certification review activities; and
3. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of medications intended to support a mental illness One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDD staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled, are oversight activities completed by DPH. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of participants served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including participants prescribed medications intended to support a mental illness . The sample size ranges based on the number of participants served at the site; however, it is never of only one participant and always includes at least three. From this certification review, it would be determined whether or not participants receiving medication from medication aides in accordance with physician orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Improvement (POI) addressing citations. The POI must be approved by DPH, and the provider is advised of changes that may be necessary to the POI.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH- approved Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Compliance with a participant's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five Rights (Provides the right medication, to the right participant, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Compliance with every participant's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. On an ongoing basis, when a complaint involving the performance of a Medication Aide is received by the DPH by phone, FAX or on-line, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry. The risk of continued harmful practices is eliminated by removing the medication aide from the registry.

DDD service coordination monitors the implementation of the service plan, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual service plan and semi-annual service plan. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96).

The purpose of the Medication Aide Act is to ensure the health, safety and welfare of participants through accurate, cost-effective, and safe utilization of medication aides for the administration of medications.

Medication aides are persons that are unlicensed and provide medication administration only under the direction and monitoring of:
1) A licensed health care professional whose scope of practice allows medication administration;
2) A participant with capability and capacity to make informed decision about medications for their medication (i.e. self-administration); or
3) A caretaker. Caretaker means a parent, foster parent, family member, friend, or legal guardian who provides care for a participant. A caretaker provides direction and monitoring and has capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

A caretaker has current first-hand knowledge of the participant's health status and the medications being provided, and has consistent frequent interaction with the participant. A staff member of a facility, school, or other entity is not a caretaker.

The ability to self-administer medication means that the participant is physically capable of:
• The act of taking or applying a dose of a medication;
• Taking or applying the medication according to a specific prescription or recommended protocol;
• Observing and monitoring themselves for desired effect, side effects, interactions, and contraindications of the medication, and taking appropriate actions based upon those observations;
• Receiving no assistance in any way from another person for any activity related to medication administration.

The inability to self-administer medications means the participant:
• Is not at least 19 years of age. Minor children may take their own medication(s) with appropriate caretaker monitoring;
• Does not have cognitive capacity to make informed decision about taking medications;
• Is not physically able to take or apply a dose of a medication;
• Does not have capability and capacity to take or apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for nonprescription medication; and
• Does not have capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

The DD provider agency must evaluate a participant's medication administration abilities, and determine the level of assistance needed for medication administration.

For participants who do not have the capability and capacity to make informed decision about medications and for whom there are not caretakers, acceptance of responsibility for direction and monitoring must be provided by a licensed health care professional.

Documentation may be accomplished by any of the following methods:

(1) When licensed health care professionals are employees, entities may identify on an individual basis or by title and job description/role delineation the licensed health care professional or the classification(s) of licensed health care professionals who are responsible to provide direction and monitoring. Written acceptance of responsibility is not required to be participant-specific and can be through acceptance of title and job description/role delineation.

(2) When licensed health care professionals are not employees, entities must identify the licensed health care professional by name, profession, and license number who is designated to provide direction and monitoring. Written acceptance of responsibility needs to be participant-specific.

(3) A licensed health care professional who provides services directly to a participant for direction and monitoring, rather than indirectly through facility employment, needs to have a written contract with the participant or other responsible party on behalf of the participant which identifies acceptance of said responsibility.

The minimum competency standards are defined in regulations. Medication aides and other unlicensed persons who provide medication must:

(1) Recognize the participant's right to personal privacy regarding health status, any diagnosis of illness, medication therapy and items of a similar nature. Information of this nature should only be shared with appropriate interdisciplinary team members.

(2) Recognize and honor the right of those participants, with capability and capacity to make an informed decision about medications, to refuse medications and at no time to be forced to take medications. In the case of a participant who does not have the capability and capacity to make informed decision about medications, recognize the requirement to seek advice and consultation from the caretaker or the licensed health care professional providing direction and monitoring regarding the procedures and persuasive methods to be used to encourage compliance with medication provision. Recognize that persuasive methods should not include anything that causes injury to the participant.

(3) Follow currently acceptable standards in hygiene and infection control including hand washing.

(4) Follow facility policies and procedures regarding storage and handling of medication, medication expiration date, disposal of medication and similar policies and procedures implemented in the facility to safeguard medication provision to participants.

(5) Recognize general unsafe conditions indicating that the medication should not be provided including change in consistency or color of the medication, unlabeled medication or illegible medication label, and those medications that have expired. Recognize that the unsafe condition(s) should be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(6) Accurately document medication name, dose, route, and time administered, or refusal.

(7) Provide the right medication, to the right participant, at the right time, in the right dose, and by the right route.

(8) Provide medications according to the specialty needs of participant's based upon such things as age, swallowing ability, and ability to cooperate.

(9) Recognize general conditions, which may indicate an adverse reaction to medication such as rashes/hives, and recognize general changes in participant condition, which may indicate inability to receive medications. Examples include altered state of consciousness, inability to swallow medications, vomiting, inability to cooperate with receiving medications and other similar conditions. Recognize that all such conditions shall be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(10) Safely provide medications for all ages of participants according to the following routes: oral, topical, inhalation and instillation as referenced in section 005.

(11) Recognize the limits and conditions by which a medication aide or other unlicensed person may provide medications.

(12) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a vulnerable adult has been subjected to abuse or conditions or circumstances which would result in abuse in accordance with Neb. Rev. Stat. 28-372.

(13) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a child has been subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which reasonably would result in abuse or neglect in accordance with Neb. Rev. Stat. 28-711.

(14) Recognize the participant's property rights and physical boundaries.

The regulations relating to medication aides specify that direction and monitoring of the medication administration completed by medication aides will be completed on an ongoing basis. The DD provider agency must have policies and procedures in place for monitoring medication administration by medication aides.

State Statute 71-1132.01 to 71-1132.53, the Nurse Practice Act also applies. The Nurse Practice Act specifies that practice of nursing by a registered nurse means assuming responsibility and accountability for nursing actions which include delegating, directing, or assigning nursing interventions that may be performed by others, and do not conflict with the Act.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Medication errors are any violation of the "Five Rights" - providing the right medication, to the right participant, at the right time, in the right dose, and by the right route, or inaccurate documentation of medication name, dose, route, and/or time administered.

Medication errors must be reported to the person responsible for providing directions and monitoring. This person could be a prescriber, a caretaker, or a licensed health care professional.

Medication errors suspected to be abuse or neglect must be reported to DHHS Protection and Safety Services and/or Children and Family Services and/or law enforcement.

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement. The provider's QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:
a. Review and approval of each DD provider's policies and procedures during the provider initial certification process;
b. On-site certification review activities; and
c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of medications which are used in support of a mental illness. The provider must have an internal quality review system and a Review Committee. When DDS program staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DPH. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of participants served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including participants prescribed medications which are used in support of a mental illness . The sample size ranges based on the number of participants served at the site; however, it is never of only one participant and always includes at least three. From this certification review, it would be determined whether or not participants receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up and change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Improvement (POI) addressing citations. The POI must be approved by DDD, and the provider is advised of changes that may be necessary to the POI.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. Upon request by DPH, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. See G-3b.ii for a description of these competencies.

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and their status on the Medication Aide Registry is ACTIVE.

DDD service coordination monitors the implementation of the service plan, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of medications which are used in support of a mental illness is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual service plan and semi-annual service plan. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

The state monitors and tracks medication errors through certification reviews and complaint investigations completed by DHHS DPH staff and GERs. Data gathered from these methods is reviewed by the QIC. Data is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. walk-throughs), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.***
(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1. Percent of participants reviewed who received information/education about how to report abuse, neglect exploitation and other critical incidents as specified in the approved waiver. Numerator = number of participants reviewed who received information/education; Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health Records System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. The no. & % of participants for whom an allegation of abuse, neglect and/or exploitation was reported appropriately (as per Rule, policies & procedures) & investigated as required. Numerator: No. of participant files reviewed in which an allegation of abuse, neglect and/or exploitation was accurately reported & investigated as required. Denominator: The total no. of participant files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health Records system

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample: Confidence Level=95% Representative Sample: Confidence Level=95% Confidence Interval=5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
3. Percent of participants' deaths reported appropriately (as per Rule, policies and procedures). Numerator = number of participants' death reported appropriately (as per Rule, policies and procedures); Denominator = number of participants' deaths reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health records system

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1. Number and percent of service coordinators who receive training on their responsibilities as mandated reporters of abuse and neglect. Numerator- Number and percent of service coordinators who receive training on their responsibilities as mandated reporters of abuse and neglect Denominator- Total number of service coordinators.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health Records System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. Number and percent of Risk Screens administered and acted upon in accordance with DHHS policies and procedures. Numerator- Number of Risk Screens administered and acted upon appropriately in accordance with DHHS Operational Guideline for Risk Screens. Denominator- Number of risk screens and subsequent actions reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health records system

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample: Confidence Interval= 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
3. Number and percent of General Event Reports (i.e., reportable incidents) completed and acted upon in accordance with DHHS policies and procedures. Numerator- Number of General Event Reports completed and acted upon appropriately in accordance with DHHS Operational Guideline for Review of General Event Reports. Denominator- Number of General Event Reports and subsequent actions reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health records system

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample: Confidence Interval= 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1. Number and percent of allegations regarding wrongful restrictive interventions where investigations are conducted in accordance with 175 Nebraska Administrative Code 19-006.02 #6. Numerator- Number of allegations regarding wrongful restrictive interventions where investigations are conducted. Denominator- Total number of allegations of wrongful restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health records System

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1. Number and percent of waiver participants whose ISP addresses their health needs. Numerator - Number of waiver participants whose ISP addresses their health needs. Denominator- Total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Health records system

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval with +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Nebraska Revised Statute 83-1202 states that it is the intent of the Legislature that the first priority of the state in responding to the needs of persons with developmental disabilities should be to ensure that all such persons have sufficient food, housing, clothing, medical care, protections from abuse or neglect, and protection from harm. Inherent throughout the State regulations, providers of waiver services and supports must ensure that participants are free from abuse, neglect, mistreatment, and exploitation; health, safety, and well-being of the participant is a priority; and participants are treated with consideration, respect, and dignity. Nebraska Revised Statute 83-1216 and state regulations also require that all DD providers who will provide direct contact services undergo background checks. DHHS also adhere to state statute by completing background and criminal history checks prior to hiring DDD service coordinators.

Information concerning protections from abuse, neglect, mistreatment, and exploitation is provided to participants and his/her legal representative prior to the initiation of services and annually thereafter. Participants may contact DHHS Protective Services or law enforcement. Participants may also tell their DDD SC, a trusted friend, or family member who will report the suspected abuse or neglect on the participant's behalf. DHHS has a statewide toll-free number for reporting allegations which is available 24/7.

Incidents are required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved web-based service system used for incident reporting and case management, within 24 hours of the verbal report. A written summary must be submitted via the web-based incident reporting system to the Department of the provider's investigation and action taken within 14 days. DDD staff triages/reviews the information daily and makes a determination whether to do a complaint investigation or handle it in another manner.

The sample size for this review is determined by 1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR 2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The State has set up processes to address individual problems as they are discovered.

DHHS staff conduct reviews of each service plan and additional evidence of the process to ensure the service plan reflects the participant's directions, preferences, and personal and career goals. Staff ensure that the service plan is based on adequate assessments of their abilities and that health and safety issues are addressed. When variances are noted, the SC and their Supervisor are notified and take action to correct the service plan. If issues are discovered that will affect the waiver status of the participant, the SC is notified and given a date to respond. The date of response is determined by the SC Supervisor and varies between five and ten working days, based on the nature of the issue.

DDD Service Coordination monitors the implementation of the service plan to ensure the timely and efficacious delivery of all services specified in the service plan for the participant. Full reviews are conducted within 60 days of the annual and semi-annual service plans. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the participant, their family or others. The full reviews consist of checking on items grouped into six groupings: rights, habilitation, financial, service needs, health and safety, and home/work environment.

When issues or problems are discovered during a SC monitoring, the participant's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the participant, manager of services, and/or providers, etc. A timeline to address the issues and/or a service plan team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

A review of the service plan and the on-site monitoring are documented and entered into a database. This allows individual SCs to track issues that aren't resolved and for DSSs and SC Supervisors to have access to the information in aggregate form to look at the performance of individual service coordinators, and provide aggregate information for SC Supervisors, the Service Coordination Administrator, and the DDD central office. This information is reviewed and acted on, as appropriate, at the local service coordination office level.

This information is summarized and reviewed by the DDD QIC quarterly. The summarized data for the service plan review are also shared with service coordination staff at the local service coordination level and the DSSs. The implementation data summary is shared with Service Coordination, providers and DDD Central Office staff.

By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. When providers report alleged abuse and neglect of participants that is not required to be reported by law, the Protection and Safety staff share this information with DDD within 24 hours of receipt. DDD staff triages/reviews the information and makes a determination whether to complete a complaint investigation or handle it in another manner.

The database for incidents is a web-based service system used for incident reporting and case management and the database allows DDD to review and aggregate data in various formats. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on a participant and provider wide level to address the issue and to decrease the likelihood of future incidents. A summary of all the incidents and of the providers efforts are compiled into a report reviewed quarterly by the QIC. The QIC determines the need for systemic follow-up and additional areas requiring probing and/or DDD management intervention

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or more often as determined by the DDD Director.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The stated purpose of the HCBS Waivers Quality Improvement System (QIS) is to ensure the health and safety of participants through continuous participant-focused monitoring and improvement by implementing and sustaining a quality management system.

The Home and Community-Based Services (HCBS) Waiver Framework provides guidance as to the State's process for monitoring the safeguards and standards under the waiver. A set of key principles guide the QIS and are contained in the Nebraska's HCBS Quality Improvement System document. Nebraska's QIS uses an evidence-based tiered approach which includes a number of activities and processes at both the local and state levels. This system has been developed to discover whether the federal waiver assurances are being met, to remediate identified problems, and to carry out quality improvement.

The DHHS DDD Quality Improvement efforts for DDD Community Based Services are coordinated through the DDD QI Committee (QIC) comprised of representatives from DDD Central Office, DHHS Medicaid, and DDD Service Coordination. The DHHS Licensure Unit provides aggregate data as requested. The QIC meets quarterly and reviews aggregate data for statewide monitoring, incidents, complaints, investigations, and certification and review surveys, to identify trends and consider statewide changes that will support service improvement. The Committee also reviews data and reports on subjects, including, but not limited to:
• HCBS waiver service requirements
• Licensure Unit investigations, and
• Service utilization information.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes show review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

The QIC receives reports and information and provides/shares feedback and support to the service districts. The MLTC representative verbally reports activities of the QIC to his/her administrator and/or the Medicaid Director and makes all meeting minutes and reports available for his review.

The QIC minutes show review of results, recommendations for remediation, and follow-up of recommendations or assigned tasks to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future. A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

DDD Program Management staff design and monitor services, including specific performance related to service and remediation. Discovery methods under Program Management are: expenditure and utilization monitoring; technical assistance; professional research, observation and insight; contract management and monitoring; and analysis of data sources.

The DDD Quality Assurance staff provides systemic review of program outcomes and standards compliance to establish continuous improvement. Discovery methods under Quality Assurance include reviewing electronic participant data, conducting file reviews; implementing participant experience surveys; and oversight of field office supervisory efforts. DDD has begun the

process to implement the use of National Core Indicators. Use of participant/family experience surveys will be discontinued upon implementation of the National Core Indicators. The sample size for this review is determined by 1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR 2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4.

Both Program Management and Quality Assurance staff are involved in discovery related to death review; complaints; incident reports; and data collection and analysis. Quality reports include: death review data, appeals data, supervisory file review data, central office file review data, local level complaint data, central office complaint data, incident data, adult/children protective service data, electronic participant data system reports, service expenditure data, and service authorization data. Of these reports, the following are compiled by DDD staff and analyzed by the DDD administration and the Quality Improvement Committee annually or as needed: death review, appeals, supervisory file review, complaints, incidents, adult protective services, electronic participant data system reports, service expenditures, and service authorizations. If a provider is identified as of concern and DPH determines that a Continuous Improvement Plan is required, DDD and DPH staff collaboratively monitor the Plan to assure completion.

In order to assure protections, services, and supports on a systems level, the Division has established a formal certification and review process in accordance with state regulations, contract specifications, and state waiver requirements for provider agencies offering services. This certification process includes certification and service reviews of community-based providers and programs by Division of Public Health (DPH) Surveyor/Consultants, who are scheduled to visit providers in accordance with the initial provisional, 1-year, or 2-year certifications issued by DPH. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths, in services provided on a statewide level. In order to ensure continued certification as a provider of DD agency services, a formal plan of improvement is required to ensure remediation of review findings that need to be addressed. On an ongoing basis, incidents and complaints associated with certified providers which have been reported to the Division are reviewed and appropriate levels of follow-up are conducted.

The State's waiver service delivery design incorporates two functions, Services Coordination and Provider Relations. These two roles provide checks and balances as each focuses on a key area. Services Coordination staff work with participants' needs, eligibility and service planning. Provider Relations staff concentrate on issues of qualified providers, including their compliance with standards. Communications between the two functions is key and both provide continuous monitoring of service delivery.

Following discovery of needed improvement in any area, staff confer, plan and involve the Quality Improvement Committee. Lines of communication are fluid to allow information to flow to and from program and quality staff. Information also flows freely to and from the Quality Improvement Committee and to and from services coordination agencies and other contracted providers. Continuous quality improvement for the purpose of statewide systemic program enhancement occurs through any combination of the following remediation activities:
• Training and meetings. These are offered or mandated for supervisors and services coordinators, as appropriate.
• Policy or procedure development or implementation to add, revise, or clarify program expectations determined necessary for program improvement.
• Informational materials including written guidance for staff or brochures directed toward participants or the public.
• Promising practices. This includes the identification, dissemination and implementation of promising practice concepts on a statewide basis.
• Remediation of individual problems. This is the responsibility of the field service coordination offices with DDD central office staff providing the oversight to ensure completion. Technical assistance is also provided to DDD field staff on a continuous ongoing basis to aid understanding of policies and procedures and to address individual situations.
• Shared resolution. This is a formally-defined process, based on proactive partnership, to work with field staff and agencies to resolve and improve instances which (1) reflect performance below expectations that cannot be remediated through technical assistance; (2) indicate a pattern of policy or procedure non-compliance which does not include a participant safety concern; or (3) are identified through formal discovery and determined not egregious as defined in the Continuous Improvement Plan process.
• Continuous Improvement Plan. This is a formally-defined process, based on a performance oversight model managed collaboratively by DPH and DDD, to resolve and improve performance when a discovery method has identified an apparent contract violation or immediate risk to participant health and safety. This remediation is appropriate for these egregious issues as well as when other remediation has been unsuccessful or determined ineffective.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: More frequently as determined by the state DDD QI committee or mandated by the DDD Director.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DDD, in partnership with the HCBS Waiver Unit of the Nebraska Department of Health and Human Services' Medicaid and Long Term Care (MLTC) Division, is responsible for monitoring and assessing system design changes, collecting and analyzing information, determining whether the waiver requirements and assurances are met, ensuring remediation, and planning system improvement activities. The DDD Director, along with the Program Staff, is responsible for coordinating the development, implementation and monitoring of any system design changes. The DDD Director works closely with the DDD Quality Improvement Committee to assure the appropriate identified priority system issues are developed, implemented and monitored to assure system change occurs. Annual data is aggregated and compared to the previous baseline evidence to determine if the identified system change is effective.

As described above in H. a. i. (System Improvements), the State has in place a Quality Improvement System that includes discovery leading to remediation. In turn, that leads to system improvement. This is an ongoing, circular system with components of design, discovery, remediation, and operational improvement. DDD QA staff, in consultation with the DDD Director, review the Quality Improvement System (QIS) on an ongoing basis, but no less frequently than quarterly, to adjust program outcomes, determine the need to modify data sources and to develop other methods to evaluate progress and services.

DDD staff fulfill the lead role in guiding this improvement along with input from DDD field services coordination office and MLTC representatives. Specific activities are as follows:

1. Process of Aggregating Data and Monitoring Data Trends
The majority of waiver Performance Measure data are aggregated through queries from systems where data are entered directly by the worker or reporter. These systems include:
• InfoPath,
• SAS,
• N-FOCUS,
• Web-based service system used for budgeting and case management,
• SharePoint, and
• OnBase.

For data that are not entered directly into a system, data are derived from individual source documents such as audits of files or certification reports and manually tabulated as necessary.

Above and beyond waiver performance measure data, the following data points are captured through queries in the above-listed databases on a quarterly basis:
• Service coordinator performance in terms of meeting deadlines;
• Wait list management and timelines;
• Service authorizations; and
• Prevention of incidents.

2. Report Formats
Quality reports include: death review data, appeals data, supervisory file review data, central office file review data, local level complaint data, central office complaint data, incident data, adult/children protective service data, electronic participant data system reports, service expenditure data, and service authorization data. These reports reflect information via graphs, tables, and narratives. QIC minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures.

3. Communicating Results
Aggregate data are shared through the QIC with DD Administrative staff, Service Coordination staff, and other stakeholders. Data reports are submitted as requested to CMS representatives. Quarterly reports are presented at Stakeholder meetings (e.g., monthly attendance by the DDD Director at Nebraska Association of Service Providers and DD Council meetings, bi-monthly DDD Advisory Committee meetings as well as routine legislative hearings).

4. Using Data for Implementing Improvement
Data are reviewed on at least a quarterly basis through the QIC and DD Administration. Appropriate recommendations, action plans and follow-up are included within the QIC minutes.

5. Assessment of the Effectiveness of the QI Process
Evaluations of the effectiveness of the QI process are done by analyzing remediation activities, determining if timelines and outcomes are being met and their success level in addressing the original concern. In addition, effectiveness is also measured through the relevancy that collected data have in providing useful information on the timeliness and quality of services provided through waiver services; data is not collected for its own sake but rather to measure areas that require maintenance of effort or improvement in service operations and delivery.

The DDD central office management team is responsible for coordination of monitoring and analysis of system design changes. The management team works in conjunction with the QIC and the program staff to develop methods of evaluation when implementing system design changes. The goal is to clearly define the outcome desired as a function of the system change and to allow the gathering of data and other information related to the state of affairs prior to the system change.

In cases where this is not practicable, efforts are made to develop alternate strategies to capture information post hoc that will allow a determination of whether the outcome was met. In those cases, it is more difficult to attribute the outcome measurement directly to the systems changes than when adequate baseline measures can be compared to measures taken following the system change.

An example of the development and monitoring of systems changes strategies was the decision to utilize a contracted vendor web-based service system used for budgeting, case management, and reporting incidents. Prior to the implementation of the web-based reporting, incident reporting and follow-up was manually logged in by DDD staff. Incidents are verbally reported to DDD staff immediately upon the provider becoming aware and reported in writing using the web-based service system within 24 hours of the verbal report. A written summary must be submitted electronically to the Department of the provider's investigation and action taken within 14 days. DDD staff triage the written reports daily and determine the appropriate response which depends upon the type and frequency of the incident. When an incident needs investigating, the incident is entered into SharePoint, a Microsoft product, which is another example of system change. SharePoint allows DDD staff to document the investigation and disposition of each complaint. The use of the web-based application and SharePoint has improved the methods of data collection and aggregation. The QIC reviews statewide quarterly reports compiled from the databases, which identifies the types and numbers of incidents by provider within a geographical area, identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Quality management staff, program management staff, and administrative staff of the HCBS Waiver Services Unit located in the Medicaid and Long-Term Care Division evaluate the effectiveness of the waiver Quality Improvement System on a continuous, ongoing basis. Nebraska QIS strategies stratify information for each respective waiver for all services funded by DDD, including the services offered under the HCBS waivers 0394 and 4154 with developmental disabilities as well as services funded by state general funds only. The HCBS Unit located in the Division of Medicaid and Long-Term Care (MLTC) oversees the implementation of the Medicaid State Plan so all identified State Plan system issues are relayed to MLTC staff responsible for services under the Medicaid State Plan.

The evaluation of the Quality Improvement Strategy (QIS) involves assessing the effectiveness of the system in improving the quality of services as well as comparing the system to best practices. If efforts to improve the quality of services are not effective, additional analyses are conducted to identify weaknesses in the current QIS. These analyses aid in identifying potential changes to improve the efficacy of the overall system. In addition, the Quality Improvement Committee provides an additional review of the effectiveness of the QIS and makes recommendations for improvement.

The Quality Improvement Strategy is evaluated on various levels in a systematic basis. Information reviewed by the QI committee is scrutinized to assess the reliability and thus, validity of the information being presented each time a committee meeting is held.

A web-based service system for reporting critical events or incidents was implemented in April 2011 to allow for coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. DDD also utilizes the Document Library in SharePoint, an intranet application of the Microsoft Outlook software, to store current forms, policies, and procedures. InfoPath forms, another Microsoft Outlook product, are utilized for complaint investigations as well as HCBS waiver Level of Care determinations. The Document Libraries allow access and utilization by all DDD staff - disability services specialists, service coordination, surveyor/consultants, administrators, and QI staff. All metadata are organized to allow for stratification by each waiver. This allows DDD leadership to access the information as needed in a more efficient manner.

There is also a self-correcting nature based on strategies used to effect systems change. As the QIS has become more mature, the development of remediation strategies becomes influenced by the history of prior efforts. The historical access to and cooperation with various levels of personnel and resources as well as the efficacy of historical strategies all influence the development of new remediation strategies. The QI strategies are evaluated at a minimum once during the waiver period and prior to renewal.

Just as the assumption is that services can always be improved, the same concept also holds with the QIS system. Efforts are continually being made to identify areas of improvement. These include modifying data collection systems to reduce error and increase the validity of the information gathered, developing additional monitoring systems to ensure the maintenance of system improvements and eliciting additional feedback from agencies and providers regarding quality improvement issues. New technology also leads to system changes and improvements in quality improvement strategies. As new and updated web applications become available, data and processes for gathering and analyzing data are reviewed and may lead to new strategies.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial accountability, or integrity, is a joint responsibility of the Division of Developmental Disabilities (DDD) with assistance from the Division of Public Health (DPH), and the Department of Health and Human Services (DHHS) Financial Services.

DDD is responsible to ensure the integrity of the service authorization and claims processes. DDD staff authorizes services, verifies individual claims, corrects suspended claims, and tracks the participant's utilization of waiver services.

A vendor web-based authorization and case management system identifies inaccurate authorizations, claims and trending data, and DDD supervisory and management staff utilize this data to determine follow up with service coordination staff to correct errors in service authorizations or conduct monitoring activities to determine if authorizations are sufficiently linked to service delivery. This data may also lead DDD staff to conduct financial reviews of provider claims when concern is raised through monitoring, certification activities by DPH or complaint investigations.

The DHHS Financial Services division tracks audit reports, operates the cost allocation plan, prepares and monitors budget projections for the Division of Medicaid and Long-Term Care and the Division of Developmental Disabilities, prepares federal and state reports as required, and prepares the CMS-64 and 372 reports.

(a) Describe the requirements concerning the independent audit of provider agencies.
DD agency-based providers are required by contract to do an annual audit of their operations. . The scope of these independent audits includes a review of the Accounting systems of the agency in order to assess if the financial statements provide an accurate representation of its financial position and are free from material misstatement.

These independent audits are submitted to Financial Services and are reviewed by an analyst for any audit findings or exceptions that might affect State payments by or for the provider.

Independent Providers and Agency Providers that have annual operating budgets of less than $200,000 are not required to provide an independent audit. However, these providers are required to retain financial and statistical records to support and document all claims.

Services that are delivered by independent providers rather than agency-based providers do not require an independent audit. Independent providers are required to retain financial and statistical records to support and document all claims.

(b) Describe the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits.
Claims for all services are audited in the same manner.

DD waiver providers submit billings through a web-based electronic authorization and claims processing system. A pre-audit of all provider claims is completed to assure the accuracy of coding and billing. Supporting electronic documentation, including staff timecards, participant attendance records or activity schedules, program data records, or other documentation as determined by the Division must be available to Division staff upon request. The provider must maintain electronic or paper records and documentation in sufficient detail, such as staff timesheets and location of service provision, to allow state program accuracy staff to verify delivery of service to participants as certified on the electronic claim.

Independent providers that choose to submit their claims non-electronically must document on the billing document, the type of service provided, the times each service was provided, and the dates the service(s) were provided to each participant. The billing document is signed by the waiver participant or, if applicable, the family member/guardian and forwarded to DHHS staff for processing. An electronic signature is acceptable.

Audits of provider claims may be conducted in response to concerns raised by a review of electronic data, trending reports, complaints, or certification or licensure reviews. DDD central office staff will review documentation to support the claim for services. This documentation may include, but is not limited to, the provider calendar and corresponding claim, agency staff time sheets and corresponding claims, service authorizations, electronic service utilization data, and the service plan. When issues are found that may be considered fraudulent claims; those issues are referred to the DHHS Medicaid Surveillance and Utilization Review Unit, or the Medicaid Fraud Control Unit of the Nebraska Department of Justice Office of the Attorney General.

DDD also conducts internal quality assurance activities related to the use of funding. Billing and authorization data is queried monthly to track trends in costs and service use by area, provider and statewide.

Financial Services track the use of Medicaid funding and provide monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of efforts to enhance our monitoring and oversight of the use of waiver funding.

(c) Describe the agency (or agencies) responsible for conducting the financial audit program.
The State Auditor and DHHS are responsible for conducting these financial audits. The Nebraska Auditor of Public Accounts is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. The State Auditor conducts the audits on an annual basis.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of paid claims reviewed that were coded in accordance with the reimbursement methodology specified in the approved waiver.
Numerator: Number of paid claims reviewed that were coded in accordance with the reimbursement methodology specified in the approved waiver.
Denominator: Number of paid claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews: on and off site

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of paid claims reviewed which were in accordance with the reimbursement methodology specified in the approved waiver.
Numerator = Number of paid claims reviewed which were in accordance with the reimbursement methodology specified in the approved waiver.
Denominator = Number of paid claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews: on and off site

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of paid claims reviewed which have documentation to support the type, frequency, and duration of services rendered.
Numerator = Number of paid claims reviewed which have documentation to support the type, frequency, and duration of services rendered.
Denominator = Number of paid claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews: on and off site

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Financial accountability is a joint responsibility of the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) with assistance from Financial Services staff within DHHS Operations.

Quarterly off-site file reviews are conducted by DDD program accuracy staff (PAS). This review is conducted on a sample of files to ensure activities are being applied correctly, and that reviews and remediation activities are completed as assigned. The sample size for this review is determined by 1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR 2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4. PAS are responsible for reporting all individual problems requiring remediation identified during discovery processes to supervisory staff.

This information is summarized and reviewed by the DDD Quality Improvement Committee (QIC) quarterly.

An independent statewide single audit of DHHS is conducted by the State Auditor of Public Accounts (APA) office on an annual basis following each state fiscal year (July 1 - June 30). This is an audit of the financial statements of the governmental activities, the business-type activities, the aggregate discreetly presented component units, each major fund, and the aggregate remaining fund information of the State of Nebraska. The final report includes APA's findings, DHHS management responses and corrective action plans, if applicable. Financial services staff respond to findings related to the State's accounting systems. DDD staff responds to findings related to review of randomly selected participant waiver files.

The APA reviews the waiver files for compliance with the state's regulations. Each waiver file must include the waiver consent form, Service Plan, documentation of annual physical exam, service authorization form and waiver review worksheets. The APA office also requests a copy of the billing document and NFOCUS service authorization that corresponds with the service dates being tested. The authorization and billing documents are checked for accuracy of service codes and service rates, as well as for agreement with the ISP documentation. Please see Appendix I-1, I-2.b-d, I-3, and I-5 for additional information on strategies employed by the state for checks and balances and discovery of systemic issues.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local service coordination level. Quarterly reporting has been developed to ensure regular review of the results of the various QI functions. The report shows an empirical data review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The participant's DDD Service Coordinator (SC) or Community Coordination Specialist (CCS) has primary responsibility for discovery and remediation of individual problems. Discovery processes include: monitoring; conducting supervisory file reviews; reviewing incidents; and following up on complaints.

Participants are notified in writing or electronically of the authorized funding amount at the time of choosing a provider and in the development of the ISP. Checks and balances described in I-1, I-2, and I-3 are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The participant's SC/CCS authorizes the services. When discrepancies are found, designated DDD staff take action to correct errors in the authorization, such as correcting the provider, service type, service amount, and/or dates of services. A pre-audit of all provider claims is completed to assure the accuracy of coding and claim. NFOCUS, Nebraska's electronic system for authorization and claims processing, was designed to meet the CMS requirements and the HCBS DD waiver specifications.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Division of Developmental Disabilities(DDD)contracted with Navigant Consulting,Inc.(Navigant)to develop a rate modeling process for fee-for-service rates for DDD's HCBS waivers.DDD built the proposed rates upon the estimated average cost of care incurred by providers administering developmental disabilities(DD)services statewide.Each DD service has its own individual rate build-up model.The model begins with a current estimate of the cost of labor required to provide the specific service.The rate that accounts for the total cost of the service is determined by applying factors to this base labor cost. The ultimate goal was to develop a rate that is reflective of the average overall cost to administer DD services on a unit basis.
As described in the Introduction and Appendix C of this Waiver,DDD unbundled services to align with federal regulation & to pay for and record services more accurately.The unbundling process required new service definitions & rates.The unbundling timeframe didn't allow for a comprehensive rate rebasing.In lieu of this, rate setting was accomplished using cost data(items of expenditure reflected on providers' general ledgers)from a provider survey collected in 2010 to establish cost factors(e.g. administrative, program support, transportation, and employee benefits)to apply to base wage assumptions from the first quarter in 2016.This approach was amenable to providers as it provided for an inflation rate in the cost factors equal to that observed in the base wage.DDD solicited feedback from Stakeholders(in bi-weekly rate setting workgroup sessions to inform & validate assumptions in the rate model.In addition, the DDD held monthly Stakeholder meetings to solicit public comment on the rate development process & preliminary rates.Meeting notices are announced on the DDD public website(http://dhhs.ne.gov/developmental disabilities/Pages/developmental disabilities index.aspx).

Nebraska will begin to reexamine rates in December 2016. The state will complete this comprehensive rate methodology study no later than September 1, 2017. An Amendment to this waiver for the prospective rate methodology will be submitted to CMS upon completion. Upon approval of the new rate methodology, the new rates will be implemented.Thereafter, Nebraska will reexamine rates at least every five years, upon renewal of its waivers.At the time of each biennium budget request, DDD examines the need for rate adjustments or rebasing.Prior to this rate adjustment, DDD rebased DD HCBS rates in 2011.When the State Legislature appropriated funds, the rates were implemented in July 2014.

DDD developed rates specific to independent providers based on stakeholder feedback & the goal to provide more services to be able to be purchased with the participant's prospective individual budget amount. DDD established independent provider rates in the proposed rates to reflect additional habilitation opportunities for self-directed services and provider qualifications for habilitative services.The rate models for independent providers have different assumptions to compensate for differences compared to agency providers(e.g. there are no supervisory costs, & lower administrative costs).

DDD also changed the rate structure for certain services from 11 levels to 4 tiers.These tiered rates were a result of provider feedback to reduce billing complexity.Certain cost factors vary by tier within a given service.The following services have a tiered rate:Habilitative Community Inclusion & Habilitative Workshop.The reimbursement for these services are tiered based on participant's level of service need as determined by the ICAP assessment.The 4 reimbursement tiers are:
o Basic-ICAP levels 7-11.
o Intermediate-ICAP levels 4-6.
o High–ICAP levels 2&3.
o Advanced–ICAP level 1.
A more detailed description of these tiers and the Objective Assessment Process(OAP)is provided in the MAIN-B-Optional section.

The cost factors used to determine rates are described in the list below.Indirect cost factors were determined based on the proportion of the factor to total direct service workers salaries, wages & benefits observed in the provider survey responses.All factors are based on the median observed proportion with the exception of the Agency Administrative factor of 19.60% which reflects the 35th percentile of observed responses.An Uppercase letter is assigned to each in order to demonstrate algebraically the calculation of rates.
A. Direct Care Staff Cost:This factor represents the hourly cost of direct care staff for a service.It is based on a "blended" wage model that considers variation in the skill level & compensation of staff providing the service.Hourly wage assumptions in this model are listed below along with a parenthetical reference to the basis of the estimate.Lowercase letters are assigned to each staff type for later demonstration of rate development.
a.Direct Care Worker:$13.10(Beatrice State Developmental Center a.k.a. BSDC wage data, more detail on why this data source was used is provided in MAIN-B-Optional)
b.Direct Care Worker-Overnight Asleep:$9.00(NE minimum wage)
c.Advanced Direct Care Worker:$16.05(BSDC wage data)
d.Direct Care Trainers:$14.75(BSDC wage data)
e.Supervisor:$17.42(BSDC wage data)
f.Independent Provider Direct Care Worker:$16.05(BSDC wage data)
g.Vocational Trainer: $16.05(BSDC wage data)
h.Behavioral Health Bachelor's Level:$40.65(OMNI Behavioral Health wage data, more detail on why this data source was used is provided in MAIN-B-Optional)
i.Respite:$11.23(from 2010 provider survey wages, updated for inflation and increase to NE minimum wage)
B.Direct Care Hours/Day:Number of direct care hours assumed in daily rates for respite. This factor is based on Assumed Staffing Ratios, and the number of hours that the participant spends outside of the residence each week.
C.Assumed Staffing Ratios(Awake):Number of direct care staff required to provide services.Staffing Ratios vary based on level of service need for tiered services.
D.Assumed Staffing Ratios(Asleep):Number of direct care staff required to provide services when the participant is asleep.This factor is only applicable to daily respite rates.
E.Benefits: This factor compensates providers for benefits (FICA taxes, health insurance, retirement, etc.)provided to employees.This factor is set at 30.28%.
F.Productivity Factor:This provides for expenses related to non-billable activities(e.g. individual support plan meetings, travel time between clients, record keeping, staff meetings, program development, etc.).The factor is based on the estimated proportion of a work week spent in non-billable activities and varies by service type.
G.FTE Factor:This provides for expenses related to paid time off(PTO)and an allowance for staff to attend training.The factor assumes 17 days for PTO and 7 for training.Considering these 24 days as 192 hours(8 hours/day)& applying a conventional 2,080 hours(52 weeks times 40 hours/week)assumption for an FTE, the factor is calculated at 9.23% (192/2,080).
H.Supervisor wage factor:Hourly wage of supervisory staff($17.42).
I.Supervisor Span of Control:The ratio of supervisors to direct care workers.This is 1:9 for all services with the exception of the advanced tiers where it is 1:6.The basis for this delineation was provider feedback that direct care staff supervising these participants require a greater level of supervision.
J.Administrative:These expenses include administrative employees'(management, accounting & finance, human resources, etc.)salaries & wages, non-payroll administrative expenses(other administrative costs including background checks, recruiting, & training),& contracted administrative services(expenditures for contracted administration services for management fees, clerical support, information technology support, professional service fees, legal expenses/attorney fee or other contracted administration services).This factor is 19.60% for Agency providers.For independent providers, only non-payroll administrative expenses are considered & a reduced factor of 4.02% is used.
K.Program Support:Expenses that are part of the operation of the setting in which services occur & related to the programs which occur within the setting, but are not directly tied to the direct care staff. They include program management & program operational expenses.This factor is 10.76%.
L.Transportation:In order to clearly delineate transportation costs so providers understand when a rate included costs of transportation, a separate transportation factor was created using costs related to vehicles owned or operated by providers, as reported on the 2010 cost and wage survey.This factor is 6.20%.
M.Incentive Adjustment Factor: This factor was incorporated into certain services that align with Nebraska's DDD vision to promote community inclusion, encourage competitive/integrated employment, and bring the state into compliance with its State Transition Plan in 2019. These services include Habilitative Community Inclusion, Prevocational, & Supported Employment services provided by agencies.
N.Reduction Adjustment Factor:This factor reduces rates for certain services.This factor is applied to certain services provided by 1) independent providers to better align the rates with the current individual budgets for services and 2)to other services to achieve budget neutrality(i.e.align rates with those in effect for similar services on July 1, 2016).

Calculation of Rates:
A description of the rate determination is presented algebraically for each service to illustrate the rate build up process.The rates are presented as the sum of two components, Direct Care Cost(DCC)& Indirect Care Cost(ICC),multiplied by an Adjustment Factor(Variables M & N),when applicable.Variables are defined only when they differ from those presented in the list of cost factors above:
1.Adult Day Services:
DCC=(A/C+H/I)(1+E)(1+F)(1+G)=($13.18/3.0+$17.42/9)(1+30.28%)(1+7.38%)(1+9.23%)=$9.67
Where:A=(0.95)(a)+(0.05)(d)=(0.95)($13.10)+(0.05)($14.75)=$13.18
ICC=DCC(J+K)=$9.67(0.1960+0.1076)=$2.94
Rate=$9.67+$2.94=$12.61
2.Habilitative Community Inclusion:
Independent Provider, Basic Tier:

DCC=(A/C)(1+E)(1+F)=($16.05/5)(1+30.28%)(1+9.59%)=$4.58
Where:A=f
ICC=(DCC)(J+K+L)=($4.58)(0.0402+0.1076+0.0620)=$0.96
Rate=(DCC+ICC)N=($4.58+$0.96)(0.96) = $5.32
Agency Provider, Basic Tier:
DCC=(A/C+H/I)(1+E)(1+F)(1+G)=($13.10/5+$17.42/9)(1+30.28%)(1+9.59%)(1+9.23%)=$7.10
Where:A=a
ICC=DCC(J+K+L)=$7.10(0.1960+0.1076+0.0620)=$2.60
Rate=(DCC+ICC)M=($7.10+$2.60)(1.10)=$10.67
Variables that differ by Tier:C=3 for Intermediate,C=1.5 for High,C=1 for Advanced.
3.Habilitative Workshop:
Basic Tier:
DCC=(A/C+H/I)(1+E)(1+F)(1+G)=($13.77/5+$17.42/9)(1+30.28%)(1+9.59%)(1+9.23%)=$7.31
Where:A=(0.75)(a)+(0.05)(d)+(0.20)(g)=(0.75)($13.10)+(0.05)($14.75)+(0.20)($16.05)=$13.77
ICC=DCC(J+K+L)=$7.31(0.1960+0.1076+0.0620)=$2.67
Rate=$7.31+$2.67=$9.98
Variables that differ by Tier:C=3 for Intermediate,C=1.5 for High,C=1 for Advanced.
Rate determination methods for Services in the currently approved waiver are in accordance with the methods described in the waiver application approved on July 7, 2015.
Transitional Services, Environmental Modification Assessment, Home Modification, Assistive Technology, & Vehicle Modification are provided at a market rate.
Reimbursement for Transportation service is based on the Nebraska standard for mileage reimbursement, pursuant to Neb. Rev. Stat. 81-1176.
The calculation for the remainder of the services can be found in the MAIN-B-Optional section.
Information about payment rates is made available verbally & in writing to waiver participants & providers by state DHHS staff. The waivers & rate study are posted on the DHHS public website at http://dhhs.ne.gov/medicaid/MedicaidWaiverInitiative/Pages/Home.aspx.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow from providers to the State's claims translator and downloaded to N-FOCUS, the State's electronic local web-based service systems, which is a component of MMIS, and are not routed through intermediary entities. Services are prior authorized and sent electronically to the provider in a vendor web-based service system. Service data, including the time at which services begin and end and the service delivery location, is recorded in the attendance module and a claim is generated through the vendor web-based system by providers and are electronically submitted for claims processing following the delivery of services. Billings may be submitted on paper claims and flow from providers to a designated DHHS e-mail mailbox for manually processing through the state's systems.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services are authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the state's accounting system, the Nebraska Information System (NIS).

All claims are routed through the N-FOCUS sub-system, a recognized component of MMIS, and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.

The program under which a claim is paid is stored on each individual service authorization and electronically transferred to the claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to the Nebraska Information System (NIS). N-FOCUS stores the timestamp and user ID for all new or updated information related to this process.

Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the Nebraska Information System (NIS). Claims are processed on a daily basis.

Direct billing of waiver services is provided to the State. Claims made to Medicaid are documented on the CMS-64 on a quarterly basis.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (◉) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) Claims for payment are made only when the participant was eligible for a Medicaid waiver payment on the date of service.
Waiver services must be prior authorized before payment is made. Authorizations are based upon a determination by designated DDD staff (Disability Services Specialists and DDD Service Coordination staff) that the participant meets waiver eligibility criteria, that the services are identified in the approved service plan, and that the services are not available for funding through programs funded under section 602 (16) or (17) of the Individuals with Disabilities Education Act (P.L. 94 - 142) or section 110 of the Rehabilitation Act of 1973.

b) Claims for payment are made only when the service was included in the participant's approved service plan.
The authorization and payment process includes the following steps:
1. Waiver eligibility of the participant is determined.
2. Waiver services are identified in the service plan.
3. Waiver service authorization, also known as the budget authorization, is completed, indicating approved waiver services, waiver provider(s), dates of service, and authorized units of service.
4. Authorization is entered into in a vendor web-based service system used for budget authorization, claims processing, and case management and then sent to NFOCUS, the state's electronic local web-based authorization and payment system.
5. Upon verification through the vendor web-based system, claims are electronically submitted to NFOCUS for processing. Edits in the vendor web-based system verify participant and provider

eligibility, dates of service, units of service, and rates.
6. Claims are generated based on service data entered by providers.

c) Claims for payment are made only when the services were provided.
In addition to enrollment as a Medicaid provider, all providers must sign an annual Service provider agreement and addendum as applicable, stipulating that the provider shall maintain records and documentation in sufficient detail to allow state staff to verify units of service provided to participants as certified on the state billing document. Each billing document must be signed by the provider, certifying that the foregoing claim is accurate and all services provided were in compliance with applicable state regulations.

When services are delivered by an independent provider, a description of services must be submitted on the billing document and signed by the waiver participant or, if applicable, the family member/guardian. The billing document is forwarded to DHHS staff for processing. An electronic signature is acceptable.

The billing validation process verifies that the participant was eligible for Medicaid waiver payment on the date of service.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

  Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Vocational Rehabilitation Services within the Department of Education is a state government agency. Vocational Rehabilitation Services is an independent waiver provider of Assistive Technology, Home Modifications, Vehicle Modifications, and/or Environmental Modification Assessment, and receive the same rates as all providers for those services.

In Nebraska, some agency-based DD providers are public providers established by County Commissioners under interlocal agreements. Both private and public agency-based DD providers deliver the same waiver services, and the payment to these public providers does not differ from the amount paid to private providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (•) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (•) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (•) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

This waiver does include waiver services furnished in residential settings other than the personal home of the participant.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (•) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	14576.47	4877.00	19453.47	173539.00	5323.00	178862.00	159408.53
2	15118.34	4975.00	20093.34	177009.00	5429.00	182438.00	162344.66
3	15392.23	5074.00	20466.23	180550.00	5538.00	186088.00	165621.77
4	15699.79	5176.00	20875.79	184161.00	5648.00	189809.00	168933.21
5	16028.65	5279.00	21307.65	187844.00	5761.00	193605.00	172297.35

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable) Level of Care: ICF/IID
Year 1	1055	1055
Year 2	1055	1055
Year 3	1055	1055
Year 4	1055	1055
Year 5	1055	1055

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay on the waiver is based on calendar year 2015.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The distribution of users between each service type is based on service usage patterns during calendar year 2015 (for services designated as old) and State Fiscal Year 2015 (for services designated as same and new). For services that are new to this waiver, the distribution of users by service type is estimated based on the estimated proportions of users in current services that will elect new services (i.e. new services are "crosswalked" from current services). For example, it is assumed that 40% of participants currently utilizing the Adult Day Habilitation will elect Habilitabative Community Inclusion and the remaining 60% would elect Habilitative Workshop. Consumption levels are assumed constant (i.e. the participants would consume, on average, the same number of hours of comparable services in a given week). This estimate is based on feedback received from stakeholders (e.g. Participants, Providers) on the services likely to be selected. The total number of slots is assumed to be constant and is set at 1,055 per year based on historical data from state fiscal year 2014 through state fiscal year 2016 and taking into consideration the reserved capacities for the waiver.

Estimates for number of units are based on utilization in calendar year 2015. For services that are new to this waiver, the utilization is estimated based on the estimated proportions of users in current services that will elect the new services (i.e. new services are "crosswalked" from current services).

Cost per unit estimates of services new to this waiver are based on the rate setting methodology described in appendix I. For services that were offered through this waiver in calendar year 2015, the cost per unit is based on calendar year 2015 actuals. A 2% increase is assumed for each year. Estimates for Factor D consider total consumption of each service provided at a given billing frequency. The figures (# Users, Avg. Units Per User, etc.) reflect the averages for all provider types (independent or agency), participant Acuity Tier, and/or group size possible for each service.

This waiver does not cover the cost of prescribed drugs and therefore derivation does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on actual acute care expenditures for individuals on the waiver in calendar year 2015. The average cost for acute care for this year was $4,973. Price increases of 2.0% were included for each year.

This waiver does not cover the cost of prescribed drugs and therefore Factor D'' does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The average cost of institutional care per ICF-DD recipient was based on actual expenditures in calendar year 2015. The average cost for this year was $166,800. Price increases of 2% were included for each year.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on actual acute care expenditures for individuals in an ICF-DD in calendar year 2015. The average cost for acute care for this waiver year was $5,116. Price increases of 2% were included for each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Day Habilitation	
Prevocational Services	
Respite	
Supported Employment - Individual	
Adult Companion Service	
Adult Day Services	
Assistive Technology	
Behavioral Risk Services	
Community Living and Day Supports	
Consultative Assessment Service	
Crisis Intervention Support	
Environmental Modification Assessment	
Habilitative Community Inclusion	
Habilitative Workshop	
Home Modification	
Integrated Community Employment	
Medical Risk Services	
Personal Emergency Response System (PERS)	
Retirement Services	
Supported Employment - Enclave	
Supported Employment - Follow Along	
Team Behavioral Consultation	
Transitional Services	
Transportation	

Waiver Services	
Vehicle Modification	
Vocational Planning Habilitation Service	
Workstation Habilitation Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**2469609.23**
Day Habilitation Day	Day	559	41.00	106.04	**2430330.76**	
Day Habilitation Hour	Hour	203	11.00	17.59	**39278.47**	
Prevocational Services Total:						**1021989.76**
Prevocational Services	Hour	176	179.00	32.44	**1021989.76**	
Respite Total:						**273074.68**
Respite Day	Day	160	4.00	132.17	**84588.80**	
Respite Hour	Hour	127	28.00	13.23	**47045.88**	
Respite Quarter Hour	Quarter Hour	160	272.00	3.25	**141440.00**	
Supported Employment - Individual Total:						**45854.10**
Supported Employment - Individual	Hour	10	111.00	41.31	**45854.10**	
Adult Companion Service Total:						**457271.04**
Adult Companion Service	Hour	193	192.00	12.34	**457271.04**	
Adult Day Services Total:						**0.00**
Adult Day Services	Hour	0	0.00	12.80	**0.00**	
Assistive Technology Total:						**12500.00**
Assistive Technology	Occurrence	5	1.00	2500.00	**12500.00**	
Behavioral Risk Services Total:						**0.00**
Behavioral Risk Services Day	Day	0	0.00	0.01	**0.00**	
Behavioral Risk Services Hour	Hour	0	0.00	0.01	**0.00**	
Community Living and Day Supports Total:						**381756.32**
Community Living and Day Supports Day	Day	4	10.00	13.09	**523.60**	
Community Living and Day Supports Hour	Hour	209	151.00	12.08	**381232.72**	
Consultative Assessment Service Total:						**177534.72**
Consultative Assessment Service	Hour	88	18.00	112.08	**177534.72**	
Crisis Intervention Support Total:						**127820.00**
Crisis Intervention Support	Hour	8	250.00	63.91	**127820.00**	
Environmental Modification Assessment Total:						**2000.00**
Environmental Modification Assessment	Occurrence	2	1.00	1000.00	**2000.00**	
Habilitative Community Inclusion Total:						**3528990.30**
Habilitative Community Inclusion	Hour	373	671.00	14.10	**3528990.30**	
Habilitative Workshop Total:						**4362976.96**
Habilitative Workshop	Hour	346	848.00	14.87	**4362976.96**	
Home Modification Total:						**50000.00**
Home Modification	Occurrence	5	1.00	10000.00	**50000.00**	
Integrated Community Employment Total:						**27383.60**
		GRAND TOTAL:				**15378181.00**
		Total Estimated Unduplicated Participants:				**1055**
		Factor D (Divide total by number of participants):				**14576.47**
		Average Length of Stay on the Waiver:				329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integrated Community Employment	Hour	20	34.00	40.27	27383.60	
Medical Risk Services Total:						0.00
Medical Risk Services	Day	0	0.00	0.01	0.00	
Personal Emergency Response System (PERS) Total:						960.00
Personal Emergency Response System (PERS)	Month	2	12.00	40.00	960.00	
Retirement Services Total:						0.00
Retirement Services	Hour	0	0.00	0.01	0.00	
Supported Employment - Enclave Total:						658495.00
Supported Employment - Enclave	Hour	61	850.00	12.70	658495.00	
Supported Employment - Follow Along Total:						45673.30
Supported Employment - Follow Along	Quarter Hour	10	443.00	10.31	45673.30	
Team Behavioral Consultation Total:						46051.18
Team Behavioral Consultation	Occurrence	2	1.00	23025.59	46051.18	
Transitional Services Total:						30000.00
Transitional Services	Occurrence	2	1.00	15000.00	30000.00	
Transportation Total:						1048406.25
Transportation	Mile	1055	1875.00	0.53	1048406.25	
Vehicle Modification Total:						30000.00
Vehicle Modification	Occurrence	3	1.00	10000.00	30000.00	
Vocational Planning Habilitation Service Total:						389011.64
Vocational Planning Habilitation Day	Day	2	10.00	39.19	783.80	
Vocational Planning Habilitation Hour	Hour	176	56.00	39.39	388227.84	
Workstation Habilitation Services Total:						190822.92
Workstation Habilitation Services Day	Day	59	40.00	77.59	183112.40	
Workstation Habilitation Services Hour	Hour	17	46.00	9.86	7710.52	
				GRAND TOTAL:		15378181.00
				Total Estimated Unduplicated Participants:		1055
				Factor D (Divide total by number of participants):		14576.47
				Average Length of Stay on the Waiver:		329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						0.00
Day Habilitation Day	Day	0	0.00	0.01	0.00	
Day Habilitation Hour	Hour	0	0.00	0.01	0.00	
Prevocational Services Total:						1391897.76
Prevocational Services	Hour	176	239.00	33.09	1391897.76	
Respite Total:						285481.60
Respite Day	Day	160	4.00	146.51	93766.40	
Respite Hour	Hour	0	0.00	13.49	0.00	
Respite Quarter Hour	Quarter Hour	160	362.00	3.31	191715.20	
Supported Employment - Individual Total:						268221.10
				GRAND TOTAL:		15949845.63
				Total Estimated Unduplicated Participants:		1055
				Factor D (Divide total by number of participants):		15118.34
				Average Length of Stay on the Waiver:		329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Individual	Hour	19	335.00	42.14	268221.10	
Adult Companion Service Total:						624476.59
Adult Companion Service	Hour	193	257.00	12.59	624476.59	
Adult Day Services Total:						1276549.70
Adult Day Services	Hour	173	565.00	13.06	1276549.70	
Assistive Technology Total:						12750.00
Assistive Technology	Occurrence	5	1.00	2550.00	12750.00	
Behavioral Risk Services Total:						0.00
Behavioral Risk Services Day	Day	0	0.00	0.01	0.00	
Behavioral Risk Services Hour	Hour	0	0.00	0.01	0.00	
Community Living and Day Supports Total:						0.00
Community Living and Day Supports Day	Day	0	0.00	0.01	0.00	
Community Living and Day Supports Hour	Hour	0	0.00	0.01	0.00	
Consultative Assessment Service Total:						241443.84
Consultative Assessment Service	Hour	88	24.00	114.32	241443.84	
Crisis Intervention Support Total:						130380.00
Crisis Intervention Support	Hour	8	250.00	65.19	130380.00	
Environmental Modification Assessment Total:						2040.00
Environmental Modification Assessment	Occurrence	2	1.00	1020.00	2040.00	
Habilitative Community Inclusion Total:						5926751.74
Habilitative Community Inclusion	Hour	511	806.00	14.39	5926751.74	
Habilitative Workshop Total:						2963628.40
Habilitative Workshop	Hour	346	565.00	15.16	2963628.40	
Home Modification Total:						51000.00
Home Modification	Occurrence	5	1.00	10200.00	51000.00	
Integrated Community Employment Total:						0.00
Integrated Community Employment	Hour	0	0.00	0.01	0.00	
Medical Risk Services Total:						0.00
Medical Risk Services	Day	0	0.00	0.01	0.00	
Personal Emergency Response System (PERS) Total:						979.20
Personal Emergency Response System (PERS)	Month	2	12.00	40.80	979.20	
Retirement Services Total:						0.00
Retirement Services	Hour	0	0.00	0.01	0.00	
Supported Employment - Enclave Total:						1021211.10
Supported Employment - Enclave	Hour	78	1011.00	12.95	1021211.10	
Supported Employment - Follow Along Total:						267584.60
Supported Employment - Follow Along	Quarter Hour	19	1340.00	10.51	267584.60	
Team Behavioral Consultation Total:						0.00
Team Behavioral Consultation	Occurrence	0	0.00	0.01	0.00	
Transitional Services Total:						30600.00
Transitional Services	Occurrence	2	1.00	15300.00	30600.00	
Transportation Total:						1424250.00
Transportation	Mile	1055	2500.00	0.54	1424250.00	
Vehicle Modification Total:						30600.00
Vehicle Modification					30600.00	
		GRAND TOTAL:				15949845.63
		Total Estimated Unduplicated Participants:				1055
		Factor D (Divide total by number of participants):				15118.34
		Average Length of Stay on the Waiver:				329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Occurrence	3	1.00	10200.00		
Vocational Planning Habilitation Service Total:						**0.00**
Vocational Planning Habilitation Day	Day	0	0.00	0.01	**0.00**	
Vocational Planning Habilitation Hour	Hour	0	0.00	0.01	**0.00**	
Workstation Habilitation Services Total:						**0.00**
Workstation Habilitation Services Day	Day	0	0.00	0.01	**0.00**	
Workstation Habilitation Services Hour	Hour	0	0.00	0.01	**0.00**	
			GRAND TOTAL:			**15949845.63**
			Total Estimated Unduplicated Participants:			**1055**
			Factor D (Divide total by number of participants):			**15118.34**
			Average Length of Stay on the Waiver:			329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**0.00**
Day Habilitation Day	Day	0	0.00	0.01	**0.00**	
Day Habilitation Hour	Hour	0	0.00	0.01	**0.00**	
Prevocational Services Total:						**1419660.00**
Prevocational Services	Hour	176	239.00	33.75	**1419660.00**	
Respite Total:						**291411.20**
Respite Day	Day	160	4.00	149.44	**95641.60**	
Respite Hour	Hour	0	0.00	13.76	**0.00**	
Respite Quarter Hour	Quarter Hour	160	362.00	3.38	**195769.60**	
Supported Employment - Individual Total:						**483439.04**
Supported Employment - Individual	Hour	19	592.00	42.98	**483439.04**	
Adult Companion Service Total:						**636876.84**
Adult Companion Service	Hour	193	257.00	12.84	**636876.84**	
Adult Day Services Total:						**2603926.80**
Adult Day Services	Hour	173	1130.00	13.32	**2603926.80**	
Assistive Technology Total:						**13005.00**
Assistive Technology	Occurrence	5	1.00	2601.00	**13005.00**	
Behavioral Risk Services Total:						**0.00**
Behavioral Risk Services Day	Day	0	0.00	0.01	**0.00**	
Behavioral Risk Services Hour	Hour	0	0.00	0.01	**0.00**	
Community Living and Day Supports Total:						**0.00**
Community Living and Day Supports Day	Day	0	0.00	0.01	**0.00**	
Community Living and Day Supports Hour	Hour	0	0.00	0.01	**0.00**	
Consultative Assessment Service Total:						**246280.32**
Consultative Assessment Service	Hour	88	24.00	116.61	**246280.32**	
Crisis Intervention Support Total:						**132980.00**
Crisis Intervention Support	Hour	8	250.00	66.49	**132980.00**	
Environmental Modification Assessment Total:						**2080.00**
			GRAND TOTAL:			**16238805.89**
			Total Estimated Unduplicated Participants:			**1055**
			Factor D (Divide total by number of participants):			**15392.23**
			Average Length of Stay on the Waiver:			329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification Assessment	Occurrence	2	1.00	1040.00	2080.00	
Habilitative Community Inclusion Total:						**7189018.83**
Habilitative Community Inclusion	Hour	511	959.00	14.67	7189018.83	
Habilitative Workshop Total:						**0.00**
Habilitative Workshop	Hour	0	0.00	15.47	0.00	
Home Modification Total:						**52020.00**
Home Modification	Occurrence	5	1.00	10404.00	52020.00	
Integrated Community Employment Total:						**0.00**
Integrated Community Employment	Hour	0	0.00	0.01	0.00	
Medical Risk Services Total:						**0.00**
Medical Risk Services	Day	0	0.00	0.01	0.00	
Personal Emergency Response System (PERS) Total:						**998.88**
Personal Emergency Response System (PERS)	Month	2	12.00	41.62	998.88	
Retirement Services Total:						**0.00**
Retirement Services	Hour	0	0.00	0.01	0.00	
Supported Employment - Enclave Total:						**1171542.06**
Supported Employment - Enclave	Hour	78	1137.00	13.21	1171542.06	
Supported Employment - Follow Along Total:						**482517.92**
Supported Employment - Follow Along	Quarter Hour	19	2369.00	10.72	482517.92	
Team Behavioral Consultation Total:						**0.00**
Team Behavioral Consultation	Occurrence	0	0.00	0.01	0.00	
Transitional Services Total:						**31212.00**
Transitional Services	Occurrence	2	1.00	15606.00	31212.00	
Transportation Total:						**1450625.00**
Transportation	Mile	1055	2500.00	0.55	1450625.00	
Vehicle Modification Total:						**31212.00**
Vehicle Modification	Occurrence	3	1.00	10404.00	31212.00	
Vocational Planning Habilitation Service Total:						**0.00**
Vocational Planning Habilitation Day	Day	0	0.00	0.01	0.00	
Vocational Planning Habilitation Hour	Hour	0	0.00	0.01	0.00	
Workstation Habilitation Services Total:						**0.00**
Workstation Habilitation Services Day	Day	0	0.00	0.01	0.00	
Workstation Habilitation Services Hour	Hour	0	0.00	0.01	0.00	
		GRAND TOTAL:				**16238805.89**
		Total Estimated Unduplicated Participants:				**1055**
		Factor D (Divide total by number of participants):				**15392.23**
		Average Length of Stay on the Waiver:				329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**0.00**
Day Habilitation Day	Day	0	0.00	0.01	0.00	
Day Habilitation Hour	Hour				0.00	
		GRAND TOTAL:				**16563280.92**
		Total Estimated Unduplicated Participants:				**1055**
		Factor D (Divide total by number of participants):				**15699.79**
		Average Length of Stay on the Waiver:				329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		0	0.00	0.01		
Prevocational Services Total:						**1447842.88**
Prevocational Services	Hour	176	239.00	34.42	**1447842.88**	
Respite Total:						**297372.80**
Respite Day	Day	160	4.00	152.42	**97548.80**	
Respite Hour	Hour	0	0.00	14.04	**0.00**	
Respite Quarter Hour	Quarter Hour	160	362.00	3.45	**199824.00**	
Supported Employment - Individual Total:						**493112.32**
Supported Employment - Individual	Hour	19	592.00	43.84	**493112.32**	
Adult Companion Service Total:						**649277.09**
Adult Companion Service	Hour	193	257.00	13.09	**649277.09**	
Adult Day Services Total:						**2654754.20**
Adult Day Services	Hour	173	1130.00	13.58	**2654754.20**	
Assistive Technology Total:						**13265.10**
Assistive Technology	Occurrence	5	1.00	2653.02	**13265.10**	
Behavioral Risk Services Total:						**0.00**
Behavioral Risk Services Day	Day	0	0.00	0.01	**0.00**	
Behavioral Risk Services Hour	Hour	0	0.00	0.01	**0.00**	
Community Living and Day Supports Total:						**0.00**
Community Living and Day Supports Day	Day	0	0.00	0.01	**0.00**	
Community Living and Day Supports Hour	Hour	0	0.00	0.01	**0.00**	
Consultative Assessment Service Total:						**251201.28**
Consultative Assessment Service	Hour	88	24.00	118.94	**251201.28**	
Crisis Intervention Support Total:						**135640.00**
Crisis Intervention Support	Hour	8	250.00	67.82	**135640.00**	
Environmental Modification Assessment Total:						**2122.42**
Environmental Modification Assessment	Occurrence	2	1.00	1061.21	**2122.42**	
Habilitative Community Inclusion Total:						**7336033.53**
Habilitative Community Inclusion	Hour	511	959.00	14.97	**7336033.53**	
Habilitative Workshop Total:						**0.00**
Habilitative Workshop	Hour	0	0.00	15.77	**0.00**	
Home Modification Total:						**53060.40**
Home Modification	Occurrence	5	1.00	10612.08	**53060.40**	
Integrated Community Employment Total:						**0.00**
Integrated Community Employment	Hour	0	0.00	0.01	**0.00**	
Medical Risk Services Total:						**0.00**
Medical Risk Services	Day	0	0.00	0.01	**0.00**	
Personal Emergency Response System (PERS) Total:						**1018.80**
Personal Emergency Response System (PERS)	Month	2	12.00	42.45	**1018.80**	
Retirement Services Total:						**0.00**
Retirement Services	Hour	0	0.00	0.01	**0.00**	
Supported Employment - Enclave Total:						**1195487.28**
Supported Employment - Enclave	Hour	78	1137.00	13.48	**1195487.28**	
Supported Employment - Follow Along Total:						**492420.34**
Supported Employment - Follow Along					**492420.34**	
		GRAND TOTAL:				**16563280.92**
		Total Estimated Unduplicated Participants:				**1055**
		Factor D (Divide total by number of participants):				**15699.79**
		Average Length of Stay on the Waiver:				329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Quarter Hour	19	2369.00	10.94		
Team Behavioral Consultation Total:						**0.00**
Team Behavioral Consultation	Occurrence	0	0.00	0.01	**0.00**	
Transitional Services Total:						**31836.24**
Transitional Services	Occurrence	2	1.00	15918.12	**31836.24**	
Transportation Total:						**1477000.00**
Transportation	Mile	1055	2500.00	0.56	**1477000.00**	
Vehicle Modification Total:						**31836.24**
Vehicle Modification	Occurrence	3	1.00	10612.08	**31836.24**	
Vocational Planning Habilitation Service Total:						**0.00**
Vocational Planning Habilitation Day	Day	0	0.00	0.01	**0.00**	
Vocational Planning Habilitation Hour	Hour	0	0.00	0.01	**0.00**	
Workstation Habilitation Services Total:						**0.00**
Workstation Habilitation Services Day	Day	0	0.00	0.01	**0.00**	
Workstation Habilitation Services Hour	Hour	0	0.00	0.01	**0.00**	
				GRAND TOTAL:		**16563280.92**
				Total Estimated Unduplicated Participants:		**1055**
				Factor D (Divide total by number of participants):		**15699.79**
				Average Length of Stay on the Waiver:		329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**0.00**
Day Habilitation Day	Day	0	0.00	0.01	**0.00**	
Day Habilitation Hour	Hour	0	0.00	0.01	**0.00**	
Prevocational Services Total:						**1476867.04**
Prevocational Services	Hour	176	239.00	35.11	**1476867.04**	
Respite Total:						**303379.20**
Respite Day	Day	160	4.00	155.47	**99500.80**	
Respite Hour	Hour	0	0.00	14.32	**0.00**	
Respite Quarter Hour	Quarter Hour	160	362.00	3.52	**203878.40**	
Supported Employment - Individual Total:						**503010.56**
Supported Employment - Individual	Hour	19	592.00	44.72	**503010.56**	
Adult Companion Service Total:						**662669.36**
Adult Companion Service	Hour	193	257.00	13.36	**662669.36**	
Adult Day Services Total:						**2709491.40**
Adult Day Services	Hour	173	1130.00	13.86	**2709491.40**	
Assistive Technology Total:						**13530.40**
Assistive Technology	Occurrence	5	1.00	2706.08	**13530.40**	
Behavioral Risk Services Total:						**0.00**
Behavioral Risk Services Day	Day	0	0.00	0.01	**0.00**	
Behavioral Risk Services Hour	Hour	0	0.00	0.01	**0.00**	
				GRAND TOTAL:		**16910222.35**
				Total Estimated Unduplicated Participants:		**1055**
				Factor D (Divide total by number of participants):		**16028.65**
				Average Length of Stay on the Waiver:		329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living and Day Supports Total:						**0.00**
Community Living and Day Supports Day	Day	0	0.00	0.01	**0.00**	
Community Living and Day Supports Hour	Hour	0	0.00	0.01	**0.00**	
Consultative Assessment Service Total:						**256227.84**
Consultative Assessment Service	Hour	88	24.00	121.32	**256227.84**	
Crisis Intervention Support Total:						**138360.00**
Crisis Intervention Support	Hour	8	250.00	69.18	**138360.00**	
Environmental Modification Assessment Total:						**2164.86**
Environmental Modification Assessment	Occurrence	2	1.00	1082.43	**2164.86**	
Habilitative Community Inclusion Total:						**7483048.23**
Habilitative Community Inclusion	Hour	511	959.00	15.27	**7483048.23**	
Habilitative Workshop Total:						**0.00**
Habilitative Workshop	Hour	0	0.00	0.01	**0.00**	
Home Modification Total:						**54121.60**
Home Modification	Occurrence	5	1.00	10824.32	**54121.60**	
Integrated Community Employment Total:						**0.00**
Integrated Community Employment	Hour	0	0.00	0.01	**0.00**	
Medical Risk Services Total:						**0.00**
Medical Risk Services	Day	0	0.00	0.01	**0.00**	
Personal Emergency Response System (PERS) Total:						**1039.20**
Personal Emergency Response System (PERS)	Month	2	12.00	43.30	**1039.20**	
Retirement Services Total:						**0.00**
Retirement Services	Hour	0	0.00	0.01	**0.00**	
Supported Employment - Enclave Total:						**1219432.50**
Supported Employment - Enclave	Hour	78	1137.00	13.75	**1219432.50**	
Supported Employment - Follow Along Total:						**502322.76**
Supported Employment - Follow Along	Quarter Hour	19	2369.00	11.16	**502322.76**	
Team Behavioral Consultation Total:						**0.00**
Team Behavioral Consultation	Occurrence	0	0.00	0.01	**0.00**	
Transitional Services Total:						**48709.44**
Transitional Services	Occurrence	3	1.00	16236.48	**48709.44**	
Transportation Total:						**1503375.00**
Transportation	Mile	1055	2500.00	0.57	**1503375.00**	
Vehicle Modification Total:						**32472.96**
Vehicle Modification	Occurrence	3	1.00	10824.32	**32472.96**	
Vocational Planning Habilitation Service Total:						**0.00**
Vocational Planning Habilitation Day	Day	0	0.00	0.01	**0.00**	
Vocational Planning Habilitation Hour	Hour	0	0.00	0.01	**0.00**	
Workstation Habilitation Services Total:						**0.00**
Workstation Habilitation Services Day	Day	0	0.00	0.01	**0.00**	
Workstation Habilitation Services Hour	Hour	0	0.00	0.01	**0.00**	
				GRAND TOTAL:		**16910222.35**
				Total Estimated Unduplicated Participants:		**1055**
				Factor D (Divide total by number of participants):		**16028.65**
				Average Length of Stay on the Waiver:		329